

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
FANNIE		Ethel		ADAMS		February		Day 23		Year 1969	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		Oct. 19, 1895		33 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Del.		US				Wicomico					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury		Peninsula General Hospital									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Del.		Sussex		Delmar				RD 2			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
John						Hastings		unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		14-34-1328		Mrs. Willie Marie Laurel, Del.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) cardiac failure										48 hours	
DUE TO, OR AS A CONSEQUENCE OF											
c) Metastatic Ca-generalized										12-18 mo	
DUE TO, OR AS A CONSEQUENCE OF											
f x slip - Pathologic.										2 wks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
2/20/69		Pneumonia & Sepsis		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
		HOUR A.M. Month Day Year									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from 2-11, 1969 to 2-23, 1969, that (I) (we) last saw the deceased alive on 2-23, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
Dr. R. R. R. R. R.				<input checked="" type="checkbox"/>				2/23/69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
				Burial		2/27/69		Laurel Hill		Laurel Sussex Del	
24. FUNERAL DIRECTOR		24a. ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
William M. M. M.		Delmar Del		FEB 28 1969		Charles Judge					

17080

17080

17080

17080

17080

17080

17080

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 7 Film 110 3/5/69
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03068

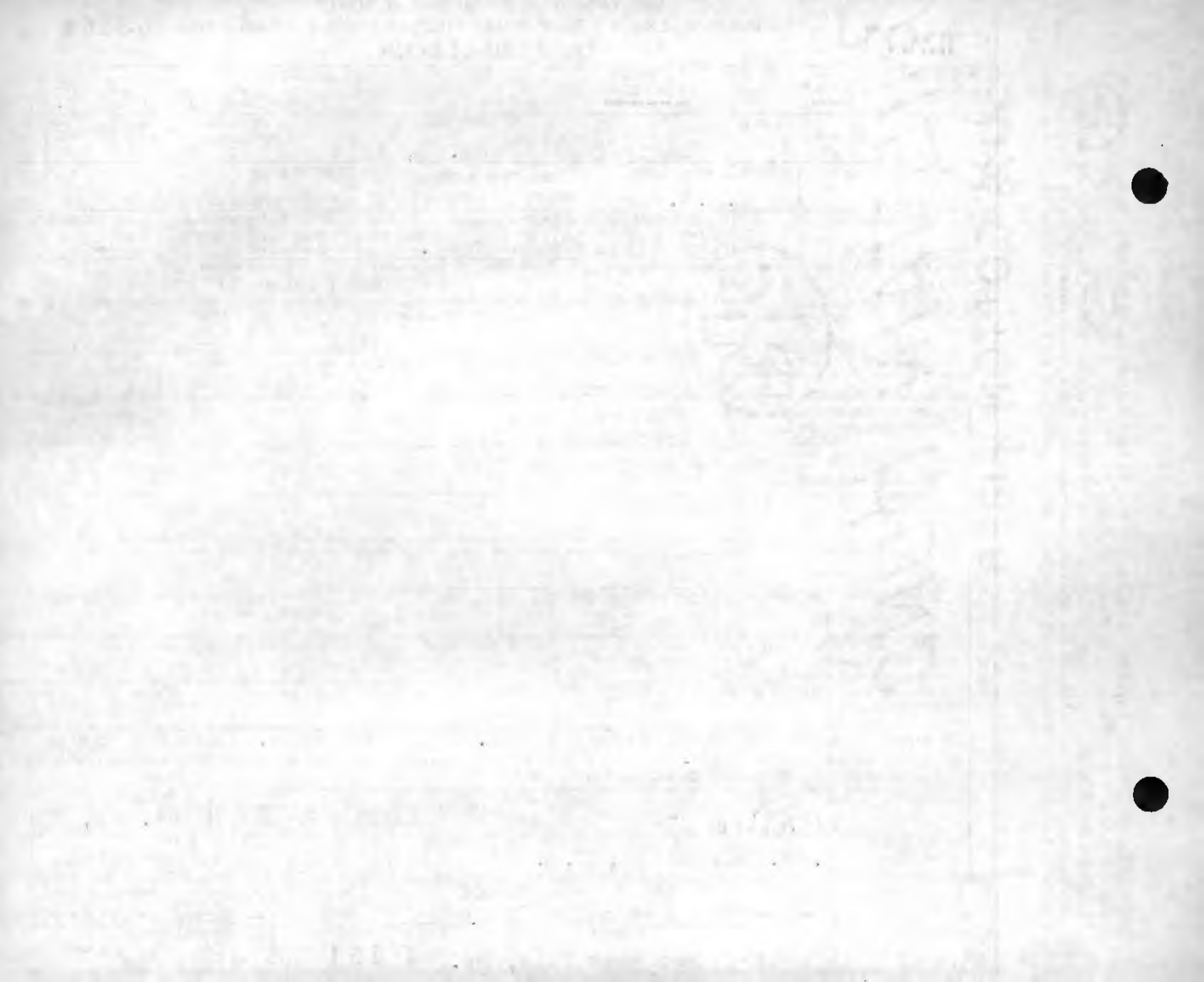
1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> 2-19-69 19		2b. HOUR 11:50 AM
CHESTER		DORSEY		AYDELOTTE			
3. SEX Male	4. RACE White	5. DATE OF BIRTH 9-10-07	6. AGE (In years last birthday) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 2 Day 19 Year 69	2d. HOUR 1 PM
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Shavox Road		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) POULTRY		12b. KIND OF BUSINESS OR INDUSTRY FARM	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Shavox Road		14. FATHER'S NAME First Middle Last EMORY AYDELOTTE		15. MOTHER'S MAIDEN NAME First Middle Last BESSIE TIMMONS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 11-12-7931		17. INFORMANT ADDRESS MRS. C. D. AYDELOTTE SALISBURY MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bullet wound of brain</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 11:50 PM 2-19-69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Shot self with .22 rifle			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) own home		21f. LOCATION Street or R.F.D. No. City or Town County State Shavox Road, Salisbury, Wicomico, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Earl L. Royer, M.D. 409 Camden Ave., Salisbury, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED Feb. 21, 1969	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2/22/69		23c. NAME OF CEMETERY OR CREMATORY RIVERSIDE		23d. LOCATION (City or Town) (County) (State) Berlin Wicomico Md.	
24. FUNERAL DIRECTOR ADDRESS Burbage Funeral Home,		Berlin, Md.		25a. REC'D BY REGISTRAR DATE FEB 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

2508

52-01-

1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03073 CERTIFICATE OF DEATH 03069									
1. DECEASED-NAME (Type or print) James Lee James Ayres					2a. DATE OF DEATH Month February Day 16 Year 1969			2b. HOUR 9:27 PM	
3. SEX male		4. RACE white		5. DATE OF BIRTH Aug. 8, 1910		6. AGE (In years last birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pine Bluff State Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY Auto			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Bennett Road	
14. FATHER'S NAME First Thomas Middle - Last Ayres			15. MOTHER'S MAIDEN NAME First Julia Middle - Last Taylor						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) -		16b. SOCIAL SECURITY NO. 201-03-5880		17. INFORMANT records of: Pine Bluff State Hospital Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL - BETWEEN ONSET AND DEATH 8 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 30, 1968 , to Feb. 16, 1969 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb. 16, 1969 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.									
22b. SIGNATURE E. P. Ritchings					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Feb. 17, 1969		
22d. PHYSICIAN'S NAME (Type) E. P. Ritchings, M.D.					22e. ADDRESS Pine Bluff State Hospital				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-19-1969		23c. NAME OF CEMETERY OR REMOVAL Wessells Cemetery		23d. LOCATION (City or Town) (County) (State) Mears - Accomack-Virginia			
24. FUNERAL DIRECTOR Robert N. Watson				ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR FEB 21 1969		25b. REGISTRAR'S SIGNATURE William J. Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151-100
45M

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)		First Clifton		Middle J. ----		Last Bakeoven Sr.		2a. DATE OF DEATH Month 2 Day 22 Year 69		2b. HOUR 11:50 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Feb. 21, 1903		6. AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.					
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Deer's Head State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. Parts Dept.		12b. KIND OF BUSINESS OR INDUSTRY Chrysler, Auto					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Galena		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER -----			
14. FATHER'S NAME First George Middle W. Last Bakeoven		15. MOTHER'S MAIDEN NAME First Lillian Middle Whitlock									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No. (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 216-18-2148		17. INFORMANT Address East, Md. Clifton J. Bakeoven, 110 E. Cecil Ave; North							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Failure 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 Days Years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Alvarez Syndrome											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 12/9/68 , 19____, to 2/22/69 , 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE L. Maldve, M.D.		22c. DATE SIGNED 2/23/69		22d. PHYSICIAN'S NAME (Type) L. Maldve, M.D.							
22e. ADDRESS Box 2018, Salisbury, Md. - 21801											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 25, 1969		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City or Town) (County) (State) Chesapeake City, Cecil, Md.					
24. FUNERAL DIRECTOR Edward Fellows & Son, Millington, Md. 21651		ADDRESS		25a. REC'D BY REGISTRAR DATE FEE 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

ASD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03075

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03071

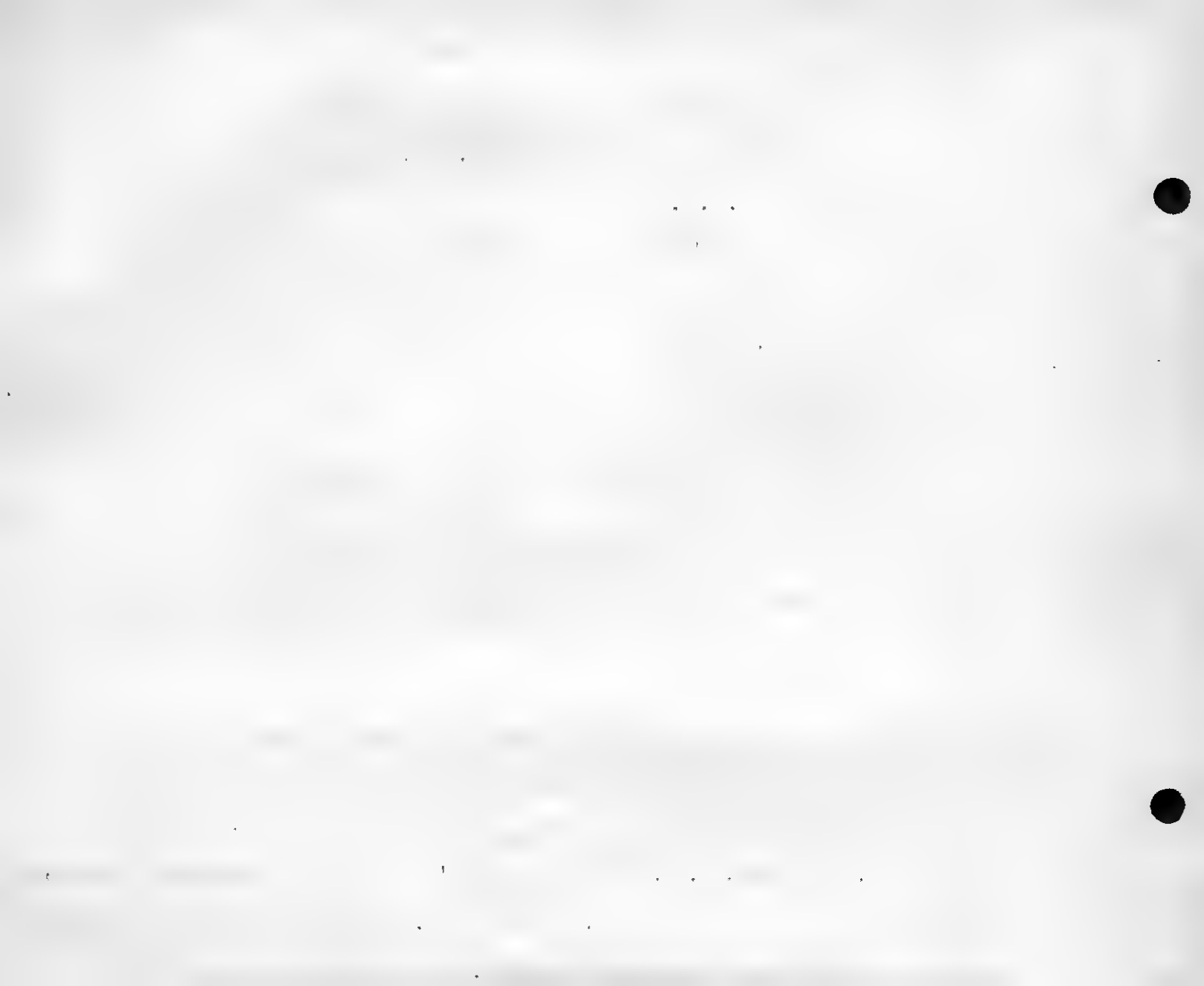
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR M		
Alexander			Ballard			February 6			1969 9 ²⁴		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
male		Negro		Mar. 4, 1891			77		IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Wicomico				
Md.		U.S.A.									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury			Peninsula General Hospital			Laborer			Factory		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Md.			Wicomico			Pocomoke			R.F.D. 1 Bx. 57		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Lafayette			Ballard			Jane			Mills		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No			213-225128			Elizabeth Ballard			Pocomoke, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive Hemorrhage CVA</u> <u>4122</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive ASC Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>1 year</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Feb. 1, 1969, to Feb. 6, 1969, that (I) (we) last saw the deceased alive on Feb. 6, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Herbert Sembly MD						22c. DATE SIGNED 2/6/69					
22d. PHYSICIAN'S NAME (Type) G. Herbert Sembly						22e. ADDRESS Salisbury Md 21801					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			2-14-69			Christ Meth. Cem. Pocomoke			Md.		
24. FUNERAL DIRECTOR Samuel Sany New Church Va						25a. REC'D BY REGISTRAR DATE FEB 13 1969			25b. REGISTRAR'S SIGNATURE John J. Jones		

[Faint, illegible handwritten text covering the majority of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
EMMA FRANCES BELL						February 12, 1969			1:30PM		
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS			
Female		White		Sept. 14, 1872		96 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Virginia		U.S.A.				WICOMICO Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury			Deer's Head State Hospital			Housewife		--			
13a. USLA. RESIDENCE (Where deceased lived; if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Worcester		Pocomoke				600 Market Street		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Asa J. Taylor						Rosa Ann Justice					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
NO			--			Mrs Bertie Beauchamp, Pocomoke City, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus									1 week		
4124 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease									Years		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (s) (this hospital) attended the deceased from June 3, 1968, to February 12, 1969, that (s) (we) last saw the deceased alive on February 12, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (s) (we) (did) (did not) view the body after death											
22b. SIGNATURE						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
L. V. Maldve, M. D.						Deer's Head State Hospital, Salisbury,					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR REMOVAL		23d. LOCATION (City or Town) (County) (State)					
Burial		2-14-1969		John W. Taylor Mem.		Temperanceville, Virginia					
24. FUNERAL DIRECTOR						25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert H. Watson Pocomoke City, Md.						FEB 17 1969					

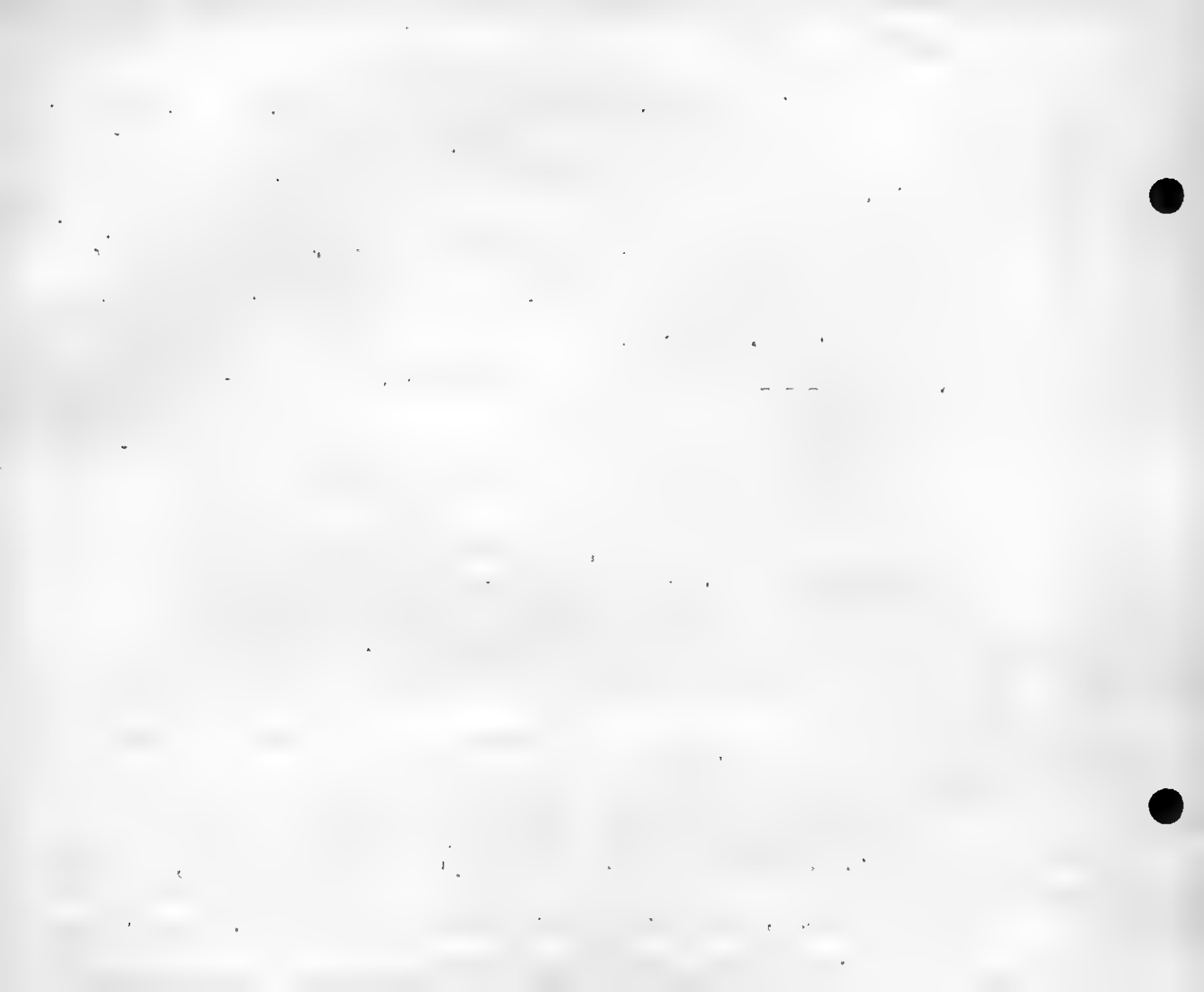


TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV. 1-58

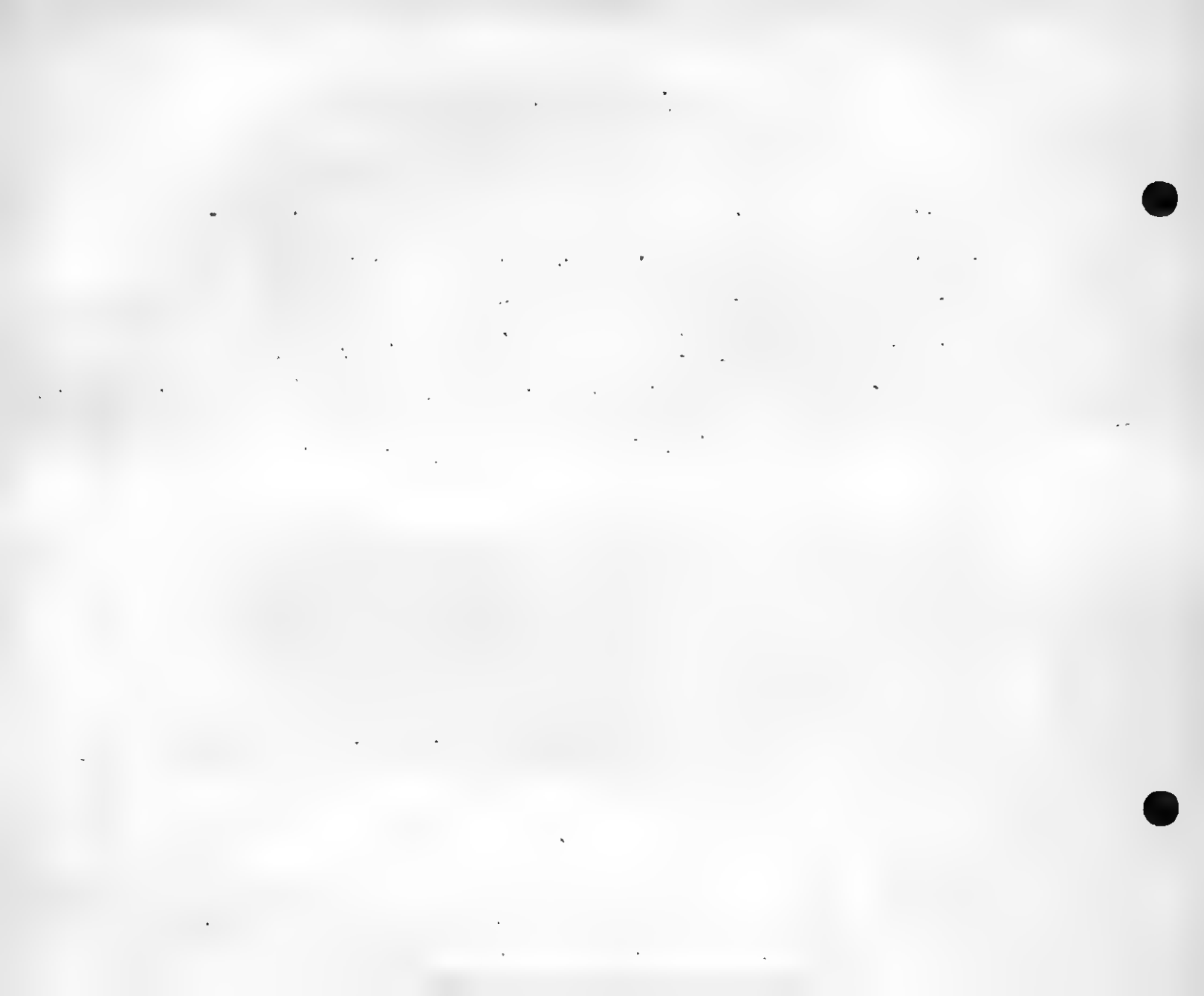
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03077 CERTIFICATE OF DEATH 03073											
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR			
HARRY			G.		BENNETT	February 2, 1969		12:55A			
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS			
Male		White		Sept. 13, 1887		81 YRS.					
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Maryland		USA				WICOMICO Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Salisbury			Deer's Head State Hospital			Waterman		Seafood			
13a USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		3a INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
Maryland			Dorchester		Cambridge		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. #3		
14. FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
John			D.		Bennett	Hester			?		Marshall
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT Address					
No						LeCompte Funeral Service records					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>										6 days	
400X DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) _____ DUE TO, OR AS A CONSEQUENCE OF											
(c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>Quadriplegia, secondary to cervical cord injury.</u>											
19a. DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>January 22, 1968</u> to <u>February 2, 1969</u> , that (I) (we) last saw the deceased alive on <u>February 2, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>C. M. Winnacott, M. D.</u>						22c. DATE SIGNED <u>2/3/69</u>					
22d. PHYSICIAN'S NAME (Type) <u>C. M. Winnacott, M. D.</u>						22e ADDRESS <u>Deer's Head State Hospital, Salisbury,</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Feb 4, 1969		Dail Family Cemetery		RFD 3, Cambridge, Maryland					
24 FUNERAL DIRECTOR ADDRESS <u>LeCompte Funeral Service, Cambridge, Maryland</u>						25a REC'D BY REGISTRAR DATE <u>FEB 6 1969</u>		25b REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03075									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First Middle Last Edna S. Bloodworth					2a. DATE OF DEATH Month Day Year 2-2-69			2b. HOUR 12:40 AM	
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH 3-7-03		6. AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wicomico Nursing Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE MARYLAND		13b. COUNTY Somerset		13c. CITY OR TOWN Princess Anne		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last Harry Schoffer			15. MOTHER'S MAIDEN NAME First Middle Last Carrie Lanett						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. 216-38-8303		17. INFORMANT Address Williams Bloodworth Salisbury					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma 1191 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 1-15, 1969, to 2-2, 1969, that (I) (we) last saw the deceased alive on 2-2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Muriel J. Newman MD					22c. DATE SIGNED 2-3-69		22d. PHYSICIAN'S NAME (Type) 22e. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/5/69		23c. NAME OF CEMETERY OR CREMATORY Salisbury Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury Wicomico Md.		23e. REC'D BY REGISTRAR DATE FEB 5 1969	
24. FUNERAL DIRECTOR R. Wilson					25b. REGISTRAR'S SIGNATURE Muriel J. Newman				



1
2
X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03079 CERTIFICATE OF DEATH 03075											
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR			
BLANCHE			LOUISA	BOWEN		February 13 1969		1:12 P-M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR			
Female		White		January 8, 1886		83 YRS.		MONTHS DAYS HOURS MIN			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Maryland		USA				Wicomico Md					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp tal give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital				Housewife		----			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland			Queen Anne Church Hill				YES <input type="checkbox"/> NO <input type="checkbox"/>		----		
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
Edwin			Brown	Walls		Mary			Louisa	Walls	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17 INFORMANT (Husband)			Address		
No			219-34-4018B			Mr. Henry C. Bowen, Church Hill,			Maryland		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) myocardial infarction										4 days	
DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic heart disease										YES	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No City or Town County State					
22a I certify that (I) (this hospital) attended the deceased from 2-8, 1969, to 2-13, 1969, that (I) (we) last saw the deceased alive on 2-13, 1969, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b SIGNATURE John T. Bulkeley M.D.						DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED Feb. 13, 1969	
22d PHYSICIAN'S NAME (Type) Dr. John T. Bulkeley						22e ADDRESS Pine Bluff Road, Salisbury, Maryland					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Burial			Feb. 15, 1969		St. Lukes Church Cemetery			Church Hill Maryland			
24 FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND						75a RECD BY REGISTRAR DATE FEB 17 1969		25b REGISTRAR'S SIGNATURE			

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13
30M REV

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03080									
03076									
1. DECEASED NAME (Type or print) <i>Sean David Bradford</i>					2a. DATE OF DEATH Month <i>February</i> Day <i>22</i> Year <i>1969</i>			2b. HOUR <i>8:30 PM</i>	
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>Feb. 29, 1969</i>		6. AGE (In years last birthday) YRS. <i>1</i> MONTHS <i>1</i> DAYS <i>43</i>		IF UNDER YEAR MONTHS <i>1</i> DAYS <i>43</i>	
7a. BIRTHPLACE (State or foreign country) <i>Wicomico</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Wicomico</i> Md.			
10. CITY OR TOWN OF DEATH <i>Salisbury-Peninsula</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>General Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>XX</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>XX</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Wicomico</i>		13c. CITY OR TOWN <i>Pittsville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>XX</i>	
14. FATHER'S NAME First <i>David</i> Middle <i>Lee</i> Last <i>Bradford</i>					15. MOTHER'S MAIDEN NAME First <i>Sandra</i> Middle <i>Schwartz</i> Last <i></i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>XX</i>		16b. SOCIAL SECURITY NO. <i>XX X</i>		17. INFORMANT Address <i>David Lee Bradford Pittsville Md</i>					
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Immaturity</i> <i>772X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>43 1/2 hr</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>2/20</i> , 19 <i>69</i> , to <i>2/22</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>2/22</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>D.S. Anderson, M.D.</i> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE/SIGNED <i>2/22/69</i>		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>2/23/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Johns</i>		23d. LOCATION (City or Town) (County) (State) <i>Pawcatuck Md Wicomico Md</i>			
24. FUNERAL DIRECTOR <i>Kelley Whaley Salisbury, Del.</i>					25a. REC'D BY REGISTRAR DATE <i>FEB 28 1969</i>		25b. REGISTRAR'S SIGNATURE <i>J. J. Jones</i>		

CERTIFICATE OF DEATH

03087

03077

1. DECEASED NAME (Type or print)		First	Middle	Last	20. DATE OF DEATH Month Day Year		2b. HOUR	
DOROTHY		JEAN	BROMLEY	Feb. 19 1969		10:00AM		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. YRS.	
Female	White		OCT. 7, 1945		23			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
MARYLAND	U.S.A.				WICOMICO			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury		Deer's Head State Hospital		none				
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, MD? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Maryland		Somerset		Eden		--		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		
WILLIAM CAMPBELL		HELEN BAKER		NO				
17. INFORMANT		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Epidermoid tumor of right posterior fossa 2320 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months		
MR. WILLIAM BROMLEY,		EDEN, MD.						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (a) (this hospital) attended the deceased from February 12, 1969, to Feb. 19, 1969, that (we) last saw the deceased alive on Feb. 19, 1969, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (not) view the body after death.								
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		
L.V. Maldve, M. D.		2/19/69		Deer's Head Hospital; Salisbury, Maryland		21801		
23a. BURIAL, CREMATION		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURNED		2/22/ 1969		ALLEN CEMETERY		ALLEN, MARYLAND		
24. FUNERAL DIRECTOR		ADDRESS		25. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
LEVIN R. WILSON		PRINCESS ANNE, MD.		FEB 21 1969		Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item 8 Film 410 3/18/69 kk									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR A M	
OLIVE MITCHELL			Burnett			February 9 1969		7:55 A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
F		W		JAN. 14, 1890		79 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W. DOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
WILLARDS MD						Wicomico Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital		HOUSEWIFE		HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		Wicomico		SALISBURY		YES		211 WALSTON AVE	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
STANFORD - MITCHELL			SALLY MARY BODLEY						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
NO			NO			MR. NORRIS MITCHELL SALISBURY MD			
18. CAUSE OF DEATH (Enter only one cause per part for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u> <u>DOX</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Anemia</u> <u>Dyskemia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify med. col. examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
21d.		21e.		21f.		21f.		21f.	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/8/69</u> to <u>2/9/69</u> , that (I) (we) last saw the deceased alive on <u>2/8/69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (and not) view the body after death.									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		2/10/69		Evergreen		Berlin Wic Md			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Ann A. Burbage				Berlin Md		FEB 13 1969		Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03083

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03079

1. DECEASED NAME (Type or print) First Middle Last Nettie Frances Carey			2a. DATE OF DEATH Month Day Year 2 10 69			2b. HOUR 11 03 PM	
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH 5-6-81		6. AGE (In years lost birthday) 87 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) wicomico Nursing Home - Booth St. Salisbury		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) House Wife		12b. KIND OF BUSINESS OR INDUSTRY OWN Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE md.		13b. COUNTY wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Johnson Rd., Rt #4		14. FATHER'S NAME First Middle Last Charles Wesley Chatham		15. MOTHER'S MAIDEN NAME First Middle Last Emma F Robertson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no (or unknown) (If yes give war or dates of service) Yes		16b. SOCIAL SECURITY NO yes		17. INFORMANT Mr. Charles C. Carey, Sr., 13 sec.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cholesterolosis DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 da 10 yr.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 2-6 , 19 68 , to 2/10 , 19 69 , that (I) (we) last saw the deceased alive on 2/10 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE Frank Weaver M.D. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 2/11/69			
22d. PHYSICIAN'S NAME (Type) FRANK Weaver M.D.		22e. ADDRESS Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2-13-1969		23c. NAME OF CEMETERY OR CREMATORY PARSONS Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, wicomico md	
24. FUNERAL DIRECTOR ADDRESS Hill Funeral Home Salisbury, Maryland				25a. REC'D BY REGISTRAR DATE FEB 13 1969		25b. REGISTRAR'S SIGNATURE William Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If removal of the certificate is required, the funeral director should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)		First <i>Adelene</i>		Middle <i>WHITE</i>		Last <i>CATHELL</i>		2a DATE OF DEATH Month <i>February</i> Day <i>15</i> Year <i>1969</i>		2b HOUR <i>11:20</i> M	
3 SEX <i>FEMALE</i>		4 RACE <i>WHITE</i>		5 DATE OF BIRTH <i>Jan. 6 1916</i>		6 AGE (In years lost birthday) <i>53</i> YRS		7 UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>Wicomico</i> Md					
10 CITY OR TOWN OF DEATH <i>Salisbury</i>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Peninsula General Hospital</i>				12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired) <i>secretary</i>		12b KIND OF BUSINESS OR INDUSTRY <i>retailing</i>	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MARYLAND</i>				13b COUNTY <i>WICOMICO</i>		13c CITY OR TOWN <i>SALISBURY</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>409 S.W. Hill Road</i>	
14. FATHER'S NAME First <i>Noah</i> Middle <i>White</i> Last <i>White</i>				15. MOTHER'S M.A.D.E.N. NAME First <i>Adell</i> Middle <i>Malone</i> Last <i>Malone</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>no</i> (If yes give war or dates of service)				16b SOCIAL SECURITY NO <i>214-10-7605</i>		17 INFORMANT <i>Maileigh N. Cathell</i> Address <i>see sec. 13</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Vascular Insufficiency</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery atherosclerosis & occlusion</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>last</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Pulmonary embolism - left cerebral embolism</i>											
19a DATE OF OPERAT ON <i>2-9-69</i>		19b CONDITION FOR WHICH OPERAT ON WAS PERFORMED <i>Coronary artery atherosclerosis</i>				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE, BUILDING, ETC				21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>1-14-1969</i> , to <i>2-15-1969</i> , that (I) (we) last saw the deceased alive on <i>2-15-1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>James B. Clifford MD</i>						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>2-16-69</i>			
22d. PHYSICIAN'S NAME (Type) <i>James Clifford MD</i>						22e. ADDRESS <i>Medical Center Salisbury Md</i>					
23a B. URIAL, CREMAT ON, REMOVAL (Specify) <i>Burial</i>		23b DATE <i>2/18/1969</i>		23c NAME OF CEMETERY OR CREMATORY <i>Wicomico Memorial Park</i>				23d LOCATION (City or Town) <i>Salisbury Wico. Maryland</i>		(County) (State)	
24 FUNERAL DIRECTOR <i>Hill Funeral Home</i>				ADDRESS <i>Salisbury</i>				25. REC'D BY REG. STRA DATE <i>FEB 19 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div> <div>83085</div> <div>CERTIFICATE OF DEATH</div> <div>03081</div> </div>									
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH				
<div>First Middle Last</div> <div>Ethel Mae Cohee</div>					<div>Feb Month 27 Day 1969 Year</div> <div>9:15 PM 2b. HOUR</div>				
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		7. YRS.
Female		White		March 12, 1893			75		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
Maryland		U.S.A.					Wicomico		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work on day even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Salisbury			Deer's Head State Hospital			Housewife			None
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INS. DE. CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Caroline		Greensboro				None
14 FATHER'S NAME First Middle Last					15 MOTHER'S MAIDEN NAME First Middle Last				
William H. Irwin					Mary Towers				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT Address				
No			219-07-5831		Mrs. Marie Weaver Greensboro, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Recurrent cerebral thrombosis									9 years
<div>4122</div> <div>Cond't ans. if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> <div>(b) Hypertensive arteriosclerotic cardiovascular disease</div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>(c)</div>									Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Chronic pyelonephritis									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/18</u> , 19 <u>69</u> , to <u>2/27</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/27</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>L. V. Maldve</i>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED <u>2/27/69</u>	
22d. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.					22e. ADDRESS Deer's Head State Hospital; Salisbury, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)	
Burial			3-2-69		Denton			Denton, Caroline, Md.	
24. FUNERAL DIRECTOR <i>John E. Bulis</i>					ADDRESS <i>Greensboro, Md.</i>		25a. REC'D BY REGISTRAR DATE MAR 3 1969		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03086

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03082

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
WILLIAM EDGAR COTTON JR.						2			15			69 10:48 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. UNDER 24 HRS	8. MONTHS	9. DAYS	10. HOURS	11. MIN.	2c. DATE PRONOUNCED DEAD			2d. HOUR		
M	W	Aug. 6, 1947	21 YRS	6	9				2			15 1969 10:48 AM		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Baltimore, Maryland			U.S.A.						Wicomico			Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury			Peninsula General Hospital			Sheet Metal Worker								
13a. USLA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY - WITS?			13e. STREET AND NUMBER		
Maryland			Wicomico			Salisbury			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			R. D. #5, Pemberton Drive		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
William Edgar Cotton Sr.			Helen N. Pross											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT								
No			214-46-4656			R.D.#5, Pemberton Dr., Salisbury, Md. Mr. William E. Cotton Sr. (Father)								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Fractured skull												days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
(b) Crushed chest												days		
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?						
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
				11 HOUR 2-13-69 PM				Driver of auto involved in 1 vehicle accident.						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State						
				road				Quantico Road, Salisbury, Wic., Md.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL CAUSE OF DEATH				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED						
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Feb. 17 /69						
23a. BURIAL, CREMATION REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)		
Burial				2-17-69				Wicomico Memorial Park				Salisbury Wicomico Maryland		
24. FUNERAL DIRECTOR				25a. REC'D BY REG STRAR				25b. REGISTRAR'S SIGNATURE						
HOLLOWAY and COMPANY				SALISBURY, MARYLAND				FEB 20 1969						

CERTIFICATE OF DEATH

03087

03083

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR A.M. P.M.	
Steven		R.		Davis	Feb. 23 1969			7:15	
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (n years last birthday)		7 UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN.
Male	White Colored		June 1906		62				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		U.S.A.				Wisconsin			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Deer's Head State Hospital		Farm Labor		Farming			
13a USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Cecil		Cecilton		YES		-----	
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last
Steven		R.		Davis	Gertrude				Mason
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b SOCIAL SECURITY NO		17 INFORMANT Address			
No.				214-18-2733		Ulysses Davis, R.F.D. Middletown, Del.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the stomach</u>									
1519 DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>& metastasis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f LOCATION		Street or R.F.D. No.		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>2/19/69</u> , 19 <u>69</u> , to <u>2/23/69</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/23/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE		22c DATE SIGNED			22d. PHYSICIAN'S NAME (Type)				
<u>W. Malve, M.D.</u>		2/23/69			L. Malve, M.D.				
22e. ADDRESS		22f. ADDRESS							
		Box 2018, Salisbury, Md. - 21801							
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)	(State)
Burial		Feb. 27, 1969		Cecilton Cemetery		Cecilton,		Cecil,	Md.
24 FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		DATE	
Edward Fellows & Son,		Millington, Md. 21651		FEB 27 1969					

■

■

■

■

■ ■ ■

■

■ ■ ■

■

■

■ ■

■ ■ ■ ■

■

■ ■ ■

■ ■ ■ ■ ■

■ ■

■

■ ■

■ ■

■



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03089

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03084

1. DECEASED-NAME (Type or Print) WELDON LOUIS DRYDEN			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 2 Day 21 Year 1969			2b. HOUR 5:05 PM			
3 SEX Male	4 RACE White	5 DATE OF BIRTH 9-12-06	6 AGE (In years last birthday) 62 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN 0	2c. DATE PRONOUNCED DEAD Month 2 Day 21 Year 1969			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General			2a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming		
13a. USUAL RESIDENCE (Where deceased lived, if institution, on residence before admission) STATE Md.			13b. COUNTY Somerset		13c. CITY OR TOWN Marion		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME First Gordon Middle Louis Last Dryden			15. MOTHER'S MAIDEN NAME First Naomi Middle -- Last Bell			13e. STREET AND NUMBER Route 1, Box 153			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. 212-16-1680		17. INFORMANT Mrs Virginia A. Dryden, Marion, Md.				
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronar. occlusion 44109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 19 P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED Feb. 24, 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-24-1969		23c. NAME OF CEMETERY OR CREMATOR Rehoboth Methodist		23d. LOCATION (City or Town) (County) (State) Rehobeth-Somerset-Md.			
24. FUNERAL DIRECTOR Robert H. Watson Watson Funeral Home, Pocomoke, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 26 1969		25b. REGISTRAR'S SIGNATURE Michael Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is to be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>03089</div> <div>Item 5 Film 409 2/21/69 kk</div> <div>CERTIFICATE OF DEATH</div> <div>03085</div>									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Ola			V.		Elias	2 Month 14 Day 69 Year			9A M
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. UNDER 1 YEAR	
Female		Negro		11/22/68 1896		72 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Md.		U.S.				Wicomico Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Tyaskin R.F.D.						Housewife		Own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Md.			Wicomico		Tyaskin		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Levin					Conway	Mararia			Conway
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
NO			6		217-09-4693 Mrs Letta Hull, Bryans Rd., Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Vascular Disease									5 yrs
DUE TO, OR AS A CONSEQUENCE OF (b) Diabetes									10 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town	County State
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (this hospital) attended the deceased from 9/20/63, 19 to 12/3, 19 68, that (I) (we) last saw the deceased alive on 12/3 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
Seth H. Hurdle									2/17/69
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Seth H. Hurdle					Hebron, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial		2/19/69		New Town Cem.			Tyaskin, Md.		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Cornelius G. Jessick					FEB 19 1969				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2) should be filed with the State Dept of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<div style="display: flex; justify-content: space-between;"> 03000 13086 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>											
1 DECEASED-NAME (Type or print) First Middle Last William B. ELLINGSWORTH						2a. DATE OF DEATH Month Day Year FEBRUARY 24 1969			2b. HOUR MIN 9 05		
3 SEX MALE		4 RACE White		5. DATE OF BIRTH December 29, 1903			6 AGE (In years last birthday) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) Delaware		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico					
10 CITY OR TOWN OF DEATH Salisbury			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired Laborer Collins &			12b KIND OF BUSINESS OR INDUSTRY Collins &		
13a USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) STATE Delaware			13b COUNTY Sussex		13c CITY OR TOWN Millsboro		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Main Street Ryan		
14 FATHER'S NAME First Middle Last Thomas Ellingsworth				15 MOTHER'S MAIDEN NAME First Middle Last Sadie Hudson Ellingsworth							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)				16b SOCIAL SECURITY NO 221-09-7179		17 INFORMANT Address Ethel Ellingsworth, Millsboro, Del.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolus 600 X DUE TO, OR AS A CONSEQUENCE OF (b) Complications of surgery DUE TO, OR AS A CONSEQUENCE OF (c) Approximate interval between onset and death: 20 minute											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION 2/21/69		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Prostatic obstruction				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to 2/24 , 19 69 , that (I) (we) last saw the deceased alive on February 24 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Raymond M. You						M.D. DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 2/25/69	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 27, 1969		23c. NAME OF CEMETERY OR CREMATORY Millsboro Cemetery				23d. LOCATION (City or Town) (County) (State) Millsboro, Sussex, Del.			
24. FUNERAL DIRECTOR W. Douglas Nelson						ADDRESS Millsboro, Delaware		25a. REC'D BY REGISTRAR MAR 5 1969		25b. REGISTRAR'S SIGNATURE William J. Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03091

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

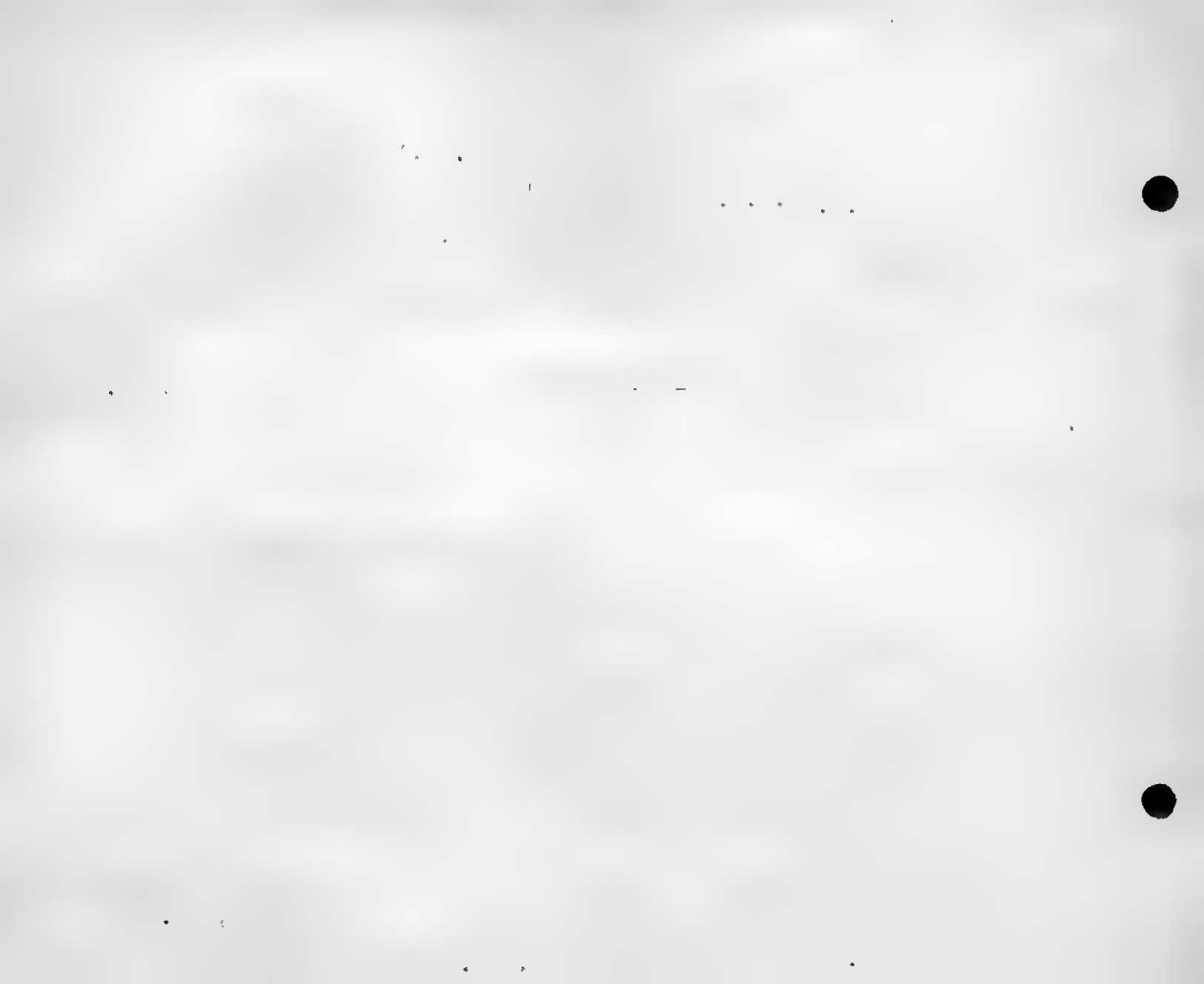
03081

1 DECEASED-NAME (Type or print) First: <u>HARRY</u> Middle: <u>MARTIN</u> Last: <u>FISHER</u>			2a. DATE OF DEATH Month: <u>2</u> Day: <u>4</u> Year: <u>1969</u>			2b. HOUR <u>11:35</u> AM					
3 SEX <u>MALE</u>		4 RACE <u>Cauc.</u>		5. DATE OF BIRTH <u>11-23-07</u>		6. AGE (In years last birthday) <u>61</u> YRS.		IF UNDER 1 YEAR MONTHS: <u></u> DAYS: <u></u>		IF UNDER 24 HRS HOURS: <u></u> MIN: <u></u>	
7a. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Wicomico</u> Md					
10. CITY OR TOWN OF DEATH <u>Salisbury</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Wicomico Nursing Home</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Inspector U.S. Dept. Agriculture</u>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <u>MARYLAND</u>		13b. COUNTY <u>Somerset</u>		13c. CITY OR TOWN <u>Princess Anne</u>		13d. INSIDE CITY, LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <u>Rt. 2</u>			
14 FATHER'S NAME First: <u>Jesse</u> Middle: <u>W.</u> Last: <u>Fisher</u>			15 MOTHER'S MAIDEN NAME First: <u>Verda</u> Middle: <u>Martin</u> Last: <u>Martin</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO			17 INFORMANT Name: <u>Mrs Mildred Fisher</u> Address: <u>RFD, Princess Anne Md</u>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pancreatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastases</u> And then, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (1) (this hospital) attended the deceased from <u>1-20</u> , 19 <u>69</u> , to <u>2-4</u> , 19 <u>69</u> , that (1) (we) last saw the deceased alive on <u>2-4</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>James J. [Signature]</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>2-5-69</u>			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2/6/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Asbury</u>		23d. LOCATION (City or Town) (County) (State) <u>McVernon Somerset Md.</u>					
24. FUNERAL DIRECTOR <u>James L. Nannon</u>						ADDRESS <u>Princess Anne</u>		25a. REC'D BY REGISTRAR <u>1-5-1-1969</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) <i>Laura W. FOSTER</i>			2a. DATE OF DEATH Month <i>FEBRUARY</i> Day <i>5</i> Year <i>1969</i>		2b. HOUR <i>6:25</i> M						
3 SEX <i>FEMALE</i>		4 RACE <i>WHITE</i>		5 DATE OF BIRTH <i>AUG. 26, 1889</i>		6 AGE (In years last birthday) <i>79</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country) <i>BETHEL, N.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Wicomico</i> Md					
10 CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Peninsula General Hospital</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>NONE</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>SOMERSET</i>		13c. CITY OR TOWN <i>PRINCESS ANNE</i>		13d. INS. DE. CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>PINE STREET</i>			
14 FATHER'S NAME First Middle Last <i>RICHARD FOSTER</i>			15 MOTHER'S MAIDEN NAME First Middle Last <i>EMMA COMBS</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <i>213-12-9558</i>		17 INFORMANT <i>NORA GREEN</i>		Address <i>PRINCESS ANNE, MD.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Isotonic Cerebrovascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute Cholelithiasis</i> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <i>2/1/69</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Acute Cholelithiasis</i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <i>2/1</i> , 19 <i>69</i> , to <i>2/5</i> , 19 <i>69</i> , that (I) (we) lost saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Richard B. Hughes</i>					DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>2/19/69</i>				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS						
23a. BURIAL, CREMATION, REINTERMENT <i>BURIAL</i>		23b. DATE <i>2/9/1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>BAPTIST CEMETERY</i>			23d. LOCATION (City or Town) (County) (State) <i>REHOBETH, MD.</i>				
24 FUNERAL DIRECTOR <i>LEVIN R. WILSON</i>					ADDRESS <i>PRINCESS ANNE, MD.</i>		25a. REC'D BY REGISTRAR <i>FEB 11 1969</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in using funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR M	
PHOEBE			PARKER		GARDNER				February 15		1969	
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Female		White		May 13, 1876			92 YRS					
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Maryland			USA				WICOMICO Md.					
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury				Springhill Private Sanitarium				Housewife		---		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b COUNTY		13c CITY OR TOWN		13a INS OF CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland				Somerset		Crisfield		YES <input type="checkbox"/> NO <input type="checkbox"/>		209 W. Main Street		
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME First Middle Last			
Eli			Littleton		Furness				Arinthia Esther Parker Handy			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No				16b SOCIAL SECURITY NO		17. INFORMANT (Daughter)				Address 209 W. Main St.		
				219-05-0513		Mrs. G. Clifford Byrd, Crisfield, Maryland						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1 DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Cerebrovascular renal disease</u>												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f LOCATION Street or R.F.D. No			City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 1, 1968</u> to <u>2-12-69</u> , that (I) (we) last saw the deceased alive on <u>2-12-69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Philip A. Insley</u>								DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED February 17/1969		
22d. PHYSICIAN'S NAME (Type) Dr. Philip A. Insley								22e. ADDRESS Salisbury, Maryland				
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)				
Cremation			Feb. 18, 1969		Silverbrook Cemetery Co.			Wilmington Delaware				
24. FUNERAL DIRECTOR ADDRESS								25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
HOLLOWAY & COMPANY, SALISBURY, MARYLAND								DATE FEB 20 1969		<u>W. C. Underwood</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> 03094 CERTIFICATE OF DEATH 93890 </div>									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
LINWOOD CALVIN			GRACIA			February 15 1969			8:24 M
3 SEX	4 RACE		5 DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male	White		April 26, 1897			71 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Maryland		USA				Wicomico Md			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury			Peninsula General Hospital			Farmer		Farming	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY, LIMITY? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Wicomico		Pittsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		Railroad Avenue
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
King Gravenor			Kate Tarr						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT (Wife)		Address		
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> or unknown <input type="checkbox"/> War I			219-07-6725		Mrs. Anna E. Gravenor, Pittsville, Maryland		Box 72		
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PULMONARY EMPHYSEMA</u>									14 HRS
2509 DUE TO, OR AS A CONSEQUENCE OF (b) <u>AMPUTATION LEG - RT</u>									36 HRS
Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause last (c) <u>DIABETES MELLITUS</u>									5 YRS
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2/12/1969						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
			Hour A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>2/12</u> , 19 <u>69</u> , to <u>2/15</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/15</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE						22c. DATE SIGNED			
<u>John M. Bloxom III</u>						2/15/1969			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
JOHN M. BLOXOM III						SALISBURY, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			Feb. 18, 1969		Line Church Cemetery		Wicomico, Maryland		
24. FUNERAL DIRECTOR ADDRESS						25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HOLLOWAY & COMPANY, SALISBURY, MARYLAND						FEB 20 1969		<u>Richard S. Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AFD
45M

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03095											
03892											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) First Middle Last SR			2a. DATE OF DEATH Month Day Year 2b HOUR								
RUSSELL H. GRIMES			FEBRUARY 23 1969 2 P. M.								
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 JUNIOR 1 YEAR		8 IF UNDER 24 HRS	
MALE		WHITE		FEB. 8 - 1905		64 YRS		MONTHS DAYS		HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
MARYLAND		USA				Wicomico Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life except retired)			12b KIND OF BUSINESS OR INDUSTRY		
Salisbury			Peninsula General Hospital			CARPENTER					
13a USUAL RESIDENCE (Where deceased lived admission)			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER		
MARYLAND			Q.A. STEVENSVILLE						Route 1		
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
WILLIAM GRIMES			FRANCES FURBUSH								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT Address						
No			214-18-9784		MRS. MOLLIE GRIMES - STEVENSVILLE MD.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypostatic Pneumonia											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last											
(b) Sepsis = Hypotension											
(c) 2° Large Decubitus											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
A-S. H. Disease & Diabetic Mellitus											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
2/15/69		Sengrene of Voes		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f LOCATION Street or RFD No		City or Town		County		State	
22a I certify that (I) (this hospital) attended the deceased from 2/11, 1969, to 2/23, 1969, that (I) (we) last saw the deceased alive on 2/23, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE										22c DATE SIGNED	
M.L.S. Brown										2/23/69	
22d PHYSICIAN'S NAME (Type)										22e ADDRESS	
M.L.S. BROWN										P.O. Box SALISBURY, MD.	
23a BURIAL, CREMATION, OR MOVING (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
BURIAL		FEB. 26		STEVENSVILLE		STEVENSVILLE MD.					
24 FUNERAL DIRECTOR ADDRESS					25a REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE				
Alyce R. Lane - CHURCH HILL MD.					FEB 25 1969		Richard Judge				

CERTIFICATE OF DEATH

03096

03092

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M		
MARY			ANNIE	GUMM	FEBRUARY 23 1969		9:22		
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
FEMALE	White		Oct. 29, 1889		79 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New Jersey		U.S.A.				Wicomico Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital		Housewife		--			
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) - STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Delaware		Sussex		Selbyville				Main Street	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Levin		Collins	Murray		Bettie		--	Onley	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
no		none		Calvin D. Gumm, Jr.,		Showell, Md.			
18. CAUSE OF DEATH (Enter only one cause per PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Massive gastrointestinal hemorrhage, site undeline.</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Arteriosclerotic Cardiovascular Disease</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>2-22, 1969</i> , to <i>2-23, 1969</i> , that (I) (we) last saw the deceased alive on <i>2-22-1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>James L. Clifford</i>				22c. DATE SIGNED <i>2-23-69</i>		22d. PHYSICIAN'S NAME (Type) James L. Clifford, M.D.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City or Town) (County) (State)			
Burial		2-25-1969		Frankford Methodist		Frankford-Sussex-Delaware			
24. FUNERAL DIRECTOR <i>Robert H. Watson</i>				ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR <i>FEB 26 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Richard J. Jones</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

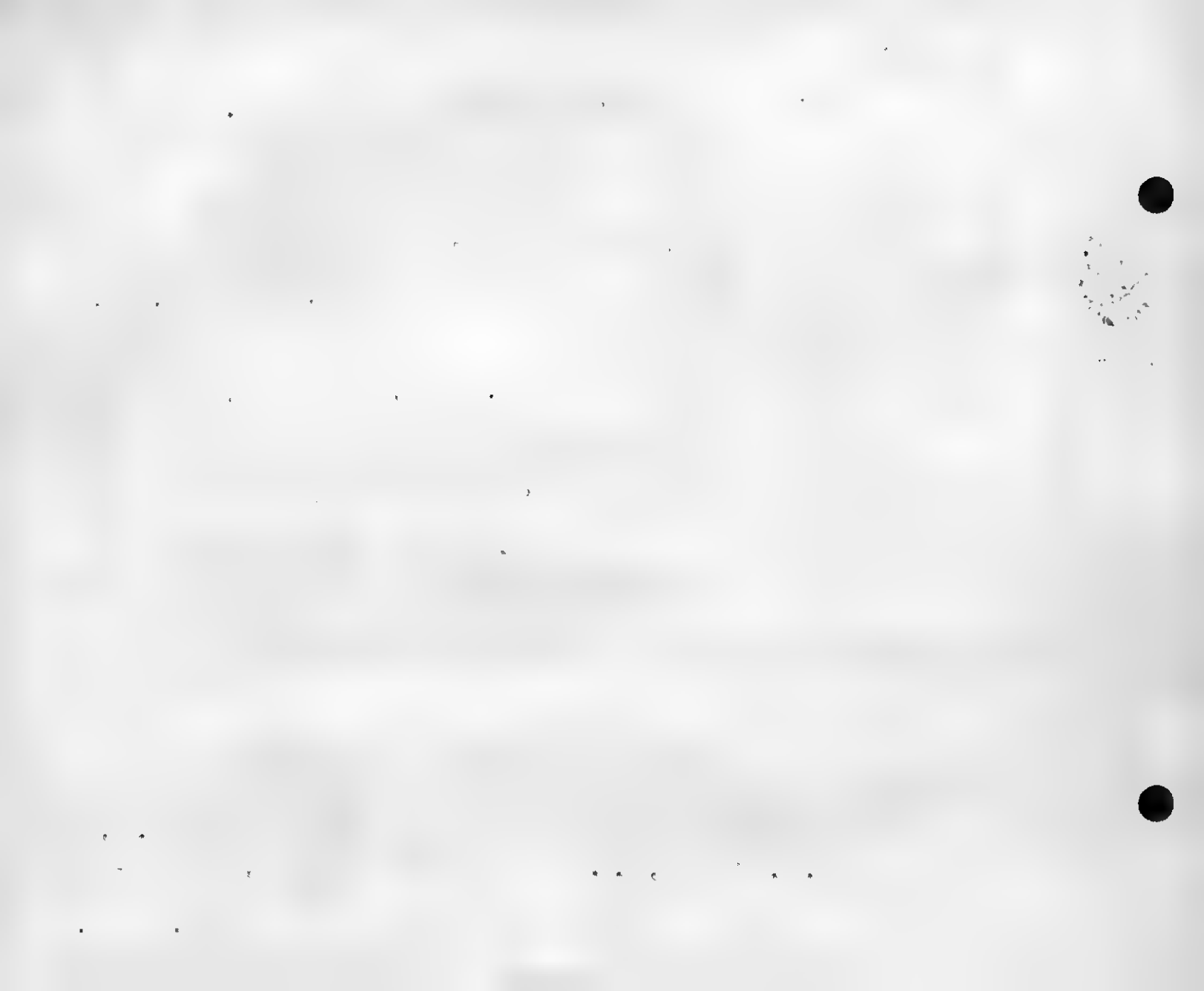
MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year			2b HOUR
MARY			ELIZABETH	GUTHRIE		February 1 1969			9:45PM
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR	
Female		White		December 16, 1893		75 YRS		MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Virginia		USA				WICOMICO Md			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General Hospital				Practical nurse		nursing	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Wicomico		Salisbury				217 S. Pineway	
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First Middle Last
Capt. John Fairfax Drummond						Mary Jane Tatman			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT (Daughter)		Address 217 S. Pineway			
No		218-05-8721A		Mrs. Virginia Mumford, Salisbury, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CVA</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>Marked Cerebral Arteriosclerosis</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) <u>Hypertension</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a I certify that (I) (this hospital) attended the deceased from <u>4/20/65</u> , 19 <u>65</u> , to <u>2/1/69</u> , 19 <u>69</u> , that (I) (we) ast saw the deceased alive on <u>2/1/69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Carrie J. Hearn</u>						22c DATE SIGNED		February 3 / 1969	
22d. PHYSICIAN'S NAME (Type) Dr. Carrie Hearn						22e ADDRESS		226 N. Division St., Salisbury, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		Feb. 5, 1969		Parsons Cemetery		Salisbury, Wicomico, Maryland			
24 FUNERAL DIRECTOR		ADDRESS		25a RECEIVED BY REG. STR.		25b REG. STR. & SIGNATURE			
HOLLOWAY & COMPANY, SALISBURY, MARYLAND				FEB 5 1969					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03098 CERTIFICATE OF DEATH 03098									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Vivian Louise Mandy						Month Day Year Feb. 2 1969			6:30 AM
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		1/9/1890		79 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Wicomico Md			
1d. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp. tal give street address)			12a. USJA. OCCUPAT ON (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury			Deer Head State Hospital			Housewife		own home	
13a. USJA. RES.DENCE (Where deceased lived, if institut on Res.dence before admiss on) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIM TS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Wicomico		Salisbury		YES		S. Division St. Rte. 1
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last Lybrand Thomas			First Middle Last Erma Webster						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT Address				
no			220 01 9266D		Mrs. Amos E. Lang see sec. 113				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema Due To Multiple Emboli									Days
1800 DUE TO, OR AS A CONSEQUENCE OF (b) Primary Carcinoma of Right Ovary Metastasis									Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Garcinoma of Right Breast									Years
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 3/12/68, 19, to 2/2/69, 19, that (I) (we) last saw the deceased alive on 2/2/69, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A. C. Mitchell, M.D.					22c. DATE SIGNED Feb. 2, 1969				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS Box 2018, Salisbury, Maryland - 21801				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		2/4/1969		Wicomico Memorial Park		Salisbury Wico.		Md.	
24. FUNERAL DIRECTOR Hill Funeral Home					ADDRESS Salisbury		25a. REC'D BY REGISTRAR FEB 5 1969		25b. REGISTRAR'S SIGNATURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03099

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03095

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <u>Jesse Thomas Hastings</u>			2a. DATE OF DEATH Month <u>8</u> Day <u>21</u> Year <u>1969</u>			2b. HOUR <u>5:55 PM</u>	
3. SEX <u>Male</u>		4. RACE <u>Cauc.</u>		5. DATE OF BIRTH <u>4-2-01</u>		6. AGE (In years last birthday) <u>67</u> YRS	
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Wicomico</u> Md.	
10. CITY OR TOWN OF DEATH <u>Salisbury</u>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <u>Wicomico Nursing Home</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>FARMER</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Worcester</u>		13c. CITY OR TOWN <u>Berlin</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <u>Rt. 2 Box 65</u>		14. FATHER'S NAME First Middle Last <u>THOMAS HASTINGS</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>ANNIE TURNER</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u>		16b. SOCIAL SECURITY NO. <u>29-36-5915</u>		17. INFORMANT <u>MRS. JESSE T. HASTINGS</u>		Address <u>Berlin Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>							<u>1 yr</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of prostate</u>							<u>2 yr</u>
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>2-10</u> , 19 <u>69</u> , to <u>2-21</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2-20</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Anne A. Burboze</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>2-22-69</u>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>2/24/69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City or Town) (County) (State) <u>BERLIN WORE MD.</u>	
24. FUNERAL DIRECTOR <u>Anne A. Burboze Berlin Md</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 28 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Maryland</u>	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the death certificate. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										03096					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH															
1 DECEASED NAME (Type or Print)			First CLEE			Middle ARTHUR			Last HAVES			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year 2-11-69 19		2b HOUR M	
3 SEX Male		4 RACE AA		5 DATE OF BIRTH 9/12/1914		6 AGE (in years last birthday) 54 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c DATE PRONOUNCED DEAD Month 2 Day 11 Year 1969		2d HOUR M			
7a BIRTHPLACE (State or foreign country) Maryland				7b CITIZEN OF WHAT COUNTRY? USA				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Wicomico Md					
10 CITY OR TOWN OF DEATH Salisbury				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) Labor				12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE Del.				13b COUNTY Sussex		13c CITY OR TOWN Delmar		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Route 2					
14 FATHER'S NAME First Middle Last Unknown						15 MOTHER'S MAIDEN NAME First Middle Last Unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>						16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Norval Hayes R.F.D. 2 Delmar Del				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Third degree burns</u> DUE TO, OR AS A CONSEQUENCE OF 8/10 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year HOUR <u>1:50</u> P.M. <u>2-7-69</u>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Fire at own home.							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm street, factory, office building, etc.) own home				21f LOCATION Street or R.F.D. No City or Town County State Route 2, Delmar Sussex Del.							
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u> 409 Camden Ave., Salisbury, Md.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						22b DATE SIGNED Feb. 14, 1969			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial				23b DATE 2/15/ 69		23c NAME OF CEMETERY OR CREMATORY Mt. Nabe				23d LOCATION (City or Town) (County) (State) Delmar Sussex Del.					
24 FUNERAL DIRECTOR Clinton S. Stewart, Salisbury, Md.						25a. REC'D BY REGISTRAR DATE FEB 19 1969				25b. REGISTRAR'S SIGNATURE					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
03101																	
03897																	
1. DECEASED NAME (Type or print)			First Mary			Middle M			Last HAYES			2a. DATE OF DEATH Month Day Year FEBRUARY 24 1969			2b. HOUR 12A M		
3 SEX F			4. RACE C			5. DATE OF BIRTH Aug. 18, 1920			6. AGE (in years last birthday) 48 YRS			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Wicomico			Md					
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Peninsula General Hospital			12a. USUA. OCCUPAT ON (Kind of work done during most of work life, even if retired) Domestic			12b. KIND OF BUSINESS OR INDUSTRY None								
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission to STATE) Maryland			13b. COUNTY Wicomico			13c. CITY OR TOWN Allen			3a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER R.F.D.#2					
14. FATHER'S NAME First Middle Last Andrew Jessels			15. MOTHER'S MAIDEN NAME First Middle Last Sadie Bird														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Sarah King R.F.D.#2			Address Allen, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) METASTASIS 1841 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CIA VULVA DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f. LOCATION Street or R.F.D. No.			City or Town			County		State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE James P. Gallaher			DEGREE ATTENDING PHYS			<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED 2/24/69								
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 3/1/69			23c. NAME OF CEMETERY OR CREMATORY Green Acres Cemetery			23d. LOCATION (City or Town) (County) (State) Salisbury Wicomico Md.								
24. FUNERAL DIRECTOR Clinton F. Stewart			ADDRESS Salisbury Md			25a. RECEIVED BY REGISTRAR FEB 27 1969			25b. REGISTRAR'S SIGNATURE								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03102

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 501 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03098

1 DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			7b. HOUR		
MAY ROSA HAYWARD						February 7, 1969			6:00 PM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR		8 IF UNDER 24 MRS	
Female		White		May 2, 1899		69 YRS.		MONTHS DAYS		HD YRS M N	
7a BIRTHPLACE (State or foreign country)		7b CIT ZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				WICOMICO Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Salisbury			Deer's Head State Hospital			Retired Seamstress			Shirt Factory		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland			Wicomico		Salisbury				625 Short Street		
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
George Franklin Cox						Priscilla Thomas					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17. INFORMANT (Son) Address						
No			214-10-8080A		Mr. Andrew W. Hayward, Salisbury, Md. 204 Pacific Ave.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Recurrent carcinoma of cervix with generalized metastasis										10 yrs (?)	
DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from November 11, 1968, to February 7, 1969, that (I) (we) last saw the deceased alive on February 7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED			
22d PHYSICIAN'S NAME (Type)						22e. ADDRESS		22f. SIGNATURE			
L. V. Maldve, M. D.						Deer's Head State Hospital, Salisbury,		2/7/69 Maryland			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		Feb. 9, 1969		Parsons Cemetery		Salisbury, Wicomico, Maryland					
24 FUNERAL DIRECTOR ADDRESS						25a DECEASED BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
HOLLOWAY & COMPANY, SALISBURY, MARYLAND						FEB 10 1969		DATE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03103

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03089

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First SHIRON	Middle A.	Last HEARNE	2a DATE OF DEATH Month Day Year FEBRUARY 19 1969		2b HOUR 7:45 PM
3 SEX 7	4 RACE NEGRO		5 DATE OF BIRTH October 27, 1968		6 AGE (In years last birthday) — YRS. 3	7 UNDER 24 HRS MONTHS 3 DAYS 23 HOURS	IF UNDER 24 HRS MIN
7a BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Wicomico Md		
10 CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital			12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY
13a US. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b COUNTY Wicomico		13c CITY OR TOWN Salisbury	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER 103 Kiowa Ave	
14. FATHER'S NAME First Middle Last RONALD HEARNE			15. MOTHER'S MA DEN NAME First Middle Last Elizabeth PARKER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO. (If yes give war or dates of service)		17 INFORMANT Address RONALD HEARNE 103 Kiowa Ave			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningitis, Pneumococcal</u> <u>SAVI</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE William C. Morgan				DEGREE ATTENDING PHYS		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type)				22c. DATE SIGNED 2/21/69			
22e. ADDRESS							
23a BURIAL, CREMATION REMOVAL (Specify) BURIAL		23b DATE 2-22-69		23c NAME OF CEMETERY OR CREMATORY Green Acres		23d LOCATION (City or Town) (County) (State) Salisbury Wico Md.	
24 FUNERAL DIRECTOR Galley Memorial Chapel				ADDRESS Rt 2 Leray Rd. Salisbury Md.		25a. REC'D BY REGISTRAR DATE FEB 26 1969	
				25b. REGISTRAR'S SIGNATURE J. H. H. H.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
First Middle Last EDWARD BRADSHAW HITCHENS					Month Day Year 2 5 1969			5P. M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
Male		White		Sept. 4, 1906		62 YRS		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U.S.A.				Wicomico Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury			Peninsula General Hospital			Cook		Pastry		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. HOUSE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Wicomico		Salisbury		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		510 Buena Vista Ave.,	
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last					
Edward L. Hitchens					Seneary Truitt					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
Yes			214-10-9572		Mrs. Vera B. Hitchens, see sec 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>Carcinoma Lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Lung</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>1-12</u> , 19 <u>64</u> , to <u>2-5</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2-5-69</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>H. B. Briele</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <u>H. B. Briele</u>					22e. ADDRESS <u>Medical Center, Salisbury, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		2-8-1969		St. Stephen's Cemetery		Delmar, Sussex, Delaware				
24. FUNERAL DIRECTOR Hill Funeral Home Salisbury, Maryland					25a. REC'D BY REGISTRAR <u>FEB 10 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03105

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03101

1. DECEASED-NAME (Type or Print)			First	Middle	Lost	20. DATE KNOWN OF DEATH			<input checked="" type="checkbox"/> ESTI <input type="checkbox"/> MATED	Month	Day	Year	2b. HOUR	
JOHN			PHILLIP	HYNSON		20. DATE KNOWN OF DEATH			<input checked="" type="checkbox"/> ESTI <input type="checkbox"/> MATED	2/10		1969	8:35 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. UNDER 1 YEAR MONTHS	8. UNDER 24 HRS DAYS	9. UNDER 24 HRS HOURS	10. UNDER 24 HRS MIN	21. DATE PRONOUNCED DEAD			Month	Day	Year	2d. HOUR
Male	White	Oct. 13, 1909	59 YRS					February 10					1969	8:35 A.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH								
Delaware		USA				WICOMICO Md.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury			Peninsula General Hospital			Supt.			Bulk Petro Plant					
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
Maryland			Wicomico			Salisbury			YES <input type="checkbox"/> NO <input type="checkbox"/>			114 Walston Avenue		
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost			
John			Wesley	Hyson		Lenora			Plummer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT (Wife)			ADDRESS					
no			221-09-3725			Mrs. Evelyn D. Hyson, Salisbury, Maryland			114 Walston Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion													sudden	
DUE TO, OR AS A CONSEQUENCE OF (b)														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>					21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)					21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>												
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>												
Earl L. Royer, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>												
409 Camden Ave., Salisbury, Md.		ADDRESS (Street, city, town, or county)												
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			25b. REGISTRAR'S SIGNATURE				
Burial		Feb. 13, 1969		Riverview Cemetery			Wilmington Delaware			25b. REGISTRAR'S SIGNATURE				
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REG. STRAR		DATE						
HOLLOWAY & COMPANY, SALISBURY, MARYLAND						FEB 13 1969		25a. REC'D BY REG. STRAR						

CERTIFICATE OF DEATH

03106

03102

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b. HOUR		
WILLIAM			F	JENKINS	February 28 69		M		
3 SEX	4. RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		
MALE	WHITE		NOV. 12, 1886		82 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
MD.		U.S.A.				Wicomico Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital		RETIRED FARMER					
13a USUA. RESIDENCE (Where deceased admitted) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
MD.		SOMERSET		PRINCESS ANNE					
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last
FELDER JENKINS					ANNA RICHARDSON				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		Address			
				MR. CLYDE JENKINS		PRINCESS ANNE, MD.			
18 CAUSE OF DEATH (Enter on any cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		4123		DUE TO, OR AS A CONSEQUENCE OF		ARTERIO SCLEROTIC HEART DISEASE			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natally medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town	
								County	
								State	
22a. I certify that (I) (this hospital) attended the deceased from 2-23, 1969 to 2-28, 1969, that (I) (we) most saw the deceased alive on 2-28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)					
WILLIAM D. ELLIS		2-28-69		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
BURIAL		3/2/1969		BEECHWOOD MEMORIAL CEMETERY		PRINCESS ANNE, MD.			
24. FUNERAL DIRECTOR		25a. REC'D BY REG STRAR		25b. REG STRAR'S SIGNATURE		25c. REC'D BY REG STRAR			
LEVIN R. WILSON		MAR 7 1969		Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> 03107 CERTIFICATE OF DEATH 03103 </div>									
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR	
First Middle Last HARRISON MARTIN JOHNSON					Month Day Year February 20, 1969			6:50AM	
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male		Colored		December 18, 1889		79 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				WICOMICO		Md	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Deer's Head State Hospital		Ret. - Crab picker		Seafood			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Talbot		St. Michaels				Thompson Street	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William B. Johnson			Mary Elize Wooters						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT				
Yes			WWI		Philadelphia, Pa.				
			216-07-5030A		Mrs. Etta Danridge, 1264 Dover St.,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY.									
IMMEDIATE CAUSE (a) Bronchopneumonia									24 hours
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) 4 x 5 X									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
Recurrent cerebral thrombosis, left hemiparesis, Hypertensive A.S. Cardiovas.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		dis.		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 8, 1968 , to February 20, 1969 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 20, 1969 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.									
22b. SIGNATURE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED		
C. H. Winnacott, M. D.							2/20/69		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
C. H. Winnacott, M. D.					Deer's Head State Hospital, Salisbury,				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Feb 22, 1969		Thomas Memorial Cemetery		St. Michaels, Maryland			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Harrison E. Leonard, St. Michaels Md.					FEB 25 1969		Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03108		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03102	
CERTIFICATE OF DEATH							
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH	
WILMORE			B.		JOHNSON	Month	Day
						Year	2b. HOUR
3. SEX			4 RACE		5. DATE OF BIRTH	6 AGE (in years last birthday)	7 F UNDER YEAR MONTHS
MALE			NEGRO		OCT. 12, 1931	37	8 YRS.
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
Md.			U.S.		9. COUNTY OF DEATH		
					Wicomico		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUA. OCCUPATION (Kind of work done during most of working life, even if retired)	
Salisbury			Peninsula General Hospital			12b KIND OF BUSINESS OR INDUSTRY	
13a U.S. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER
Md.			SOMERSET		CRISFIELD	YES	317 Locust St.
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME	
HILLARY					JOHNSON	First	Middle
						Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17. INFORMANT		
Yes, no, or unknown			1952-1954		ESTHER JOHNSON		
			214-28-3295		Address		
					CRISFIELD MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)							72 hrs
Renal failure							
DUE TO OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b)							15 days
Hepatic failure							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							36 days
Laennec's Cirrhosis							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
Obstruction of transverse colon due to constricting band							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
1-23-69		Intestinal obstruction		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
		HOUR A.M. Month Day Year					
		P.M. 19					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION			
				Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 1-20, 1969, to 2-13, 1969, that (I) (we) last saw the deceased alive on 2-13, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE						22c. DATE SIGNED	
James L. Hamby						2-16-69	
22d PHYSICIAN'S NAME (Type)						22e ADDRESS	
JAMES L. HAMBY						Pen. General Hosp. Salisbury, MD	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		2/17/69		EBENEZER		Rehoboth Md.	
24 FUNERAL DIRECTOR				ADDRESS		25a. DATE BY REGISTRAR	
Anthony E. Ward				Crisfield Md.		FEB 21 1969	
						25b. FURNITURE SIGNATURE	

03109

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First MYRA			Middle WARRINGTON		Last JONES	
2a. DATE OF DEATH			Month February			Day 7		Year 1969	
2b. HOUR			8:30 AM						
3 SEX Female		4 RACE White		5 DATE OF BIRTH May 19, 1885		6 AGE (In years last birthday) 83		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WICOMICO			
10. CITY OR TOWN OF DEATH Willards		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Main Street		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) None		12b. KIND OF BUSINESS OR INDUSTRY ---			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Willards		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER -----	
14 FATHER'S NAME First Eugene		Middle R.		Last Powell		15 MOTHER'S MAIDEN NAME First Julia		Middle Ella	
Last Gray		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO 214-42-9323		17 NEFORMANT (Sister) Miss Mattie T. Powell, Berlin, Maryland		107 Address Washington St.	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 31 months									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerosis - Hypertension</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b. TIME OF INJURY HOUR A M Month Day Year P M 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 19.35, 19, to 2-7, 1969, that (I) (we) last saw the deceased alive on 2-7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Frank R. Lewis		DEGREE Dr. FRANK R. LEWIS		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>	
22c. DATE SIGNED Feb. 10 / 1969		22d. PHYSICIAN'S NAME (Type) Willards, Maryland							
23a. BURIAL (CREMATION REMOVAL) (Specify) Burial		23b. DATE Feb. 10, 1969		23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cemetery		23d. LOCATION (City or Town) Willards, Wicomico, Maryland		(County) (State)	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 11 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03117

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03107

1 DECEASED NAME (Type or Print) ROSALEE			First Middle Last KENNEY			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 2-18-69 19			2b HOUR P 10:50 M			
3 SEX Female		4 RACE AA		5 DATE OF BIRTH 11-24-31		6 AGE (in years last birthday) 37 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico			Md.			
10 CITY OR TOWN OF DEATH Salisbury			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Domestic			12b KIND OF BUSINESS OR INDUSTRY None			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.			13b COUNTY Wicomico			13c CITY OR TOWN Salisbury			3d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
13e STREET AND NUMBER 1030 Del. Ave.			14 FATHER'S NAME First Middle Last George Cook			15 MOTHER'S MAIDEN NAME First Middle Last Alice Nelson						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) No			16b SOCIAL SECURITY NO (If yes give war or dates of service)			17 INFORMANT George Cook			ADDRESS Salisbury, Maryland			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage due to bullet wound of aorta 460 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year 10:30 PM 2-18-69				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot during altercation.				
21d. INJURY OCCURRED WHERE AT WORK <input type="checkbox"/> NOT WHERE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) own home				21f. LOCATION Street or RFD No City or Town County State 1030 Del. Ave., Salisbury, Wicomico, Md				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Carl L. Royer, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED Feb. 21, 1969				
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 2/22/69		23c. NAME OF CEMETERY OR CREMATORY Mardela Cemetery			23d. LOCATION (City or Town) (County) (State) Mardela Wicomico Md.			
24. FUNERAL DIRECTOR Clinton H. Stewart						ADDRESS Salisbury, Md.			25a. REC'D BY REGISTRAR FEB 27 1969		25b. REGISTRAR'S SIGNATURE William J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03112 CERTIFICATE OF DEATH 03108									
1 DECEASED NAME (Type or print) First Middle Last Gardner			2a. DATE OF DEATH Month Day Year FEBRUARY 13 1969			2b. HOUR 10P. M			
3 SEX MALE		4 RACE Negro		5. DATE OF BIRTH 2/2/1907		6 AGE (in years last birthday) 62 YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN 10P. M	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? U S A		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md			
10 CITY OR TOWN OF DEATH Salisbury			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired			12b. KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, (Institution Residence before admission) STATE Maryland			13b COUNTY Somerset			13c CITY OR TOWN Princess Anne		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME First Middle Last Gardner Corbin			15 MOTHER'S MAIDEN NAME First Middle Last Mary Kirwood						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RUPTURED ABD. AORTIC ANEURYSM 4412 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ANURIA. CORONARY ARTERY DISEASE									
19a. DATE OF OPERATION NONE			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12 Feb , 19 69 , to 13 Feb , 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 13 Feb , 19 69 , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE Herrick S. Warren MD			DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c. DATE SIGNED 14 Feb 69			
22d. PHYSICIAN'S NAME (Type) HERRICK S. WARREN			22e. ADDRESS P.G.H., SALISBURY, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried			23b. DATE 2/16/68		23c. NAME OF CEMETERY OR CREMATORY Tindley Chapel		23d. LOCATION (City or Town) (County) (State) Proomoke City, Maryland		
24. FUNERAL DIRECTOR ADDRESS William H. James Jr, Princess Anne, Md					25a. REC'D BY REGISTRAR DATE 19 1983		25b. REGISTRAR'S SIGNATURE		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03119

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03109

1 DECEASED NAME (Type or Print)		First ELMER		Middle THOMAS		Last LANGFORD		2a DATE KNOWN <input checked="" type="checkbox"/> Month Day Year OF EST. DEATH MATED <input type="checkbox"/> 2-7-69 19			2b HOUR 1:09 AM	
3 SEX Male	4 RACE AA	5 DATE OF BIRTH 12/8/1908		6 AGE (In years last birthday) 60+ YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month 2 Day 7 Year 69		2d HOUR 1:09 AM
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? Princess Anne, Md		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Wicomico Md.						
10 CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General				12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE Md.		13b COUNTY Somerset		13c CITY OR TOWN Princess Anne		13d INSIDE CITY LIMITS? NO <input type="checkbox"/>		13e STREET AND NUMBER Greenwood				
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO (If yes give war or dates of service)		17 INFORMANT			ADDRESS			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bullet wound of chest</u> <u>7220</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 12:40 PM 2-7-69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Accidentally shot self with .22 rifle.								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home of friend		21f. LOCATION Street or R.F.D. No. City or Town County State Greenwood, Princess Anne, Somerset, Md.								
22a I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Earl L. Royer, M.D. 409 Camden Ave., Salisbury, Md				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED Feb. 10, 1969				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2/13/69		23c. NAME OF CEMETERY OR CREMATORY Mt Hope Amez		23d. LOCATION (City or Town) (County) (State) Princess Anne, Md						
24. FUNERAL DIRECTOR'S NAME (Type) William H James Jr				ADDRESS Princess Anne, Md.		25a. REC'D BY REGISTRAR FEB 17 1969		25b. REGISTRAR'S SIGNATURE				

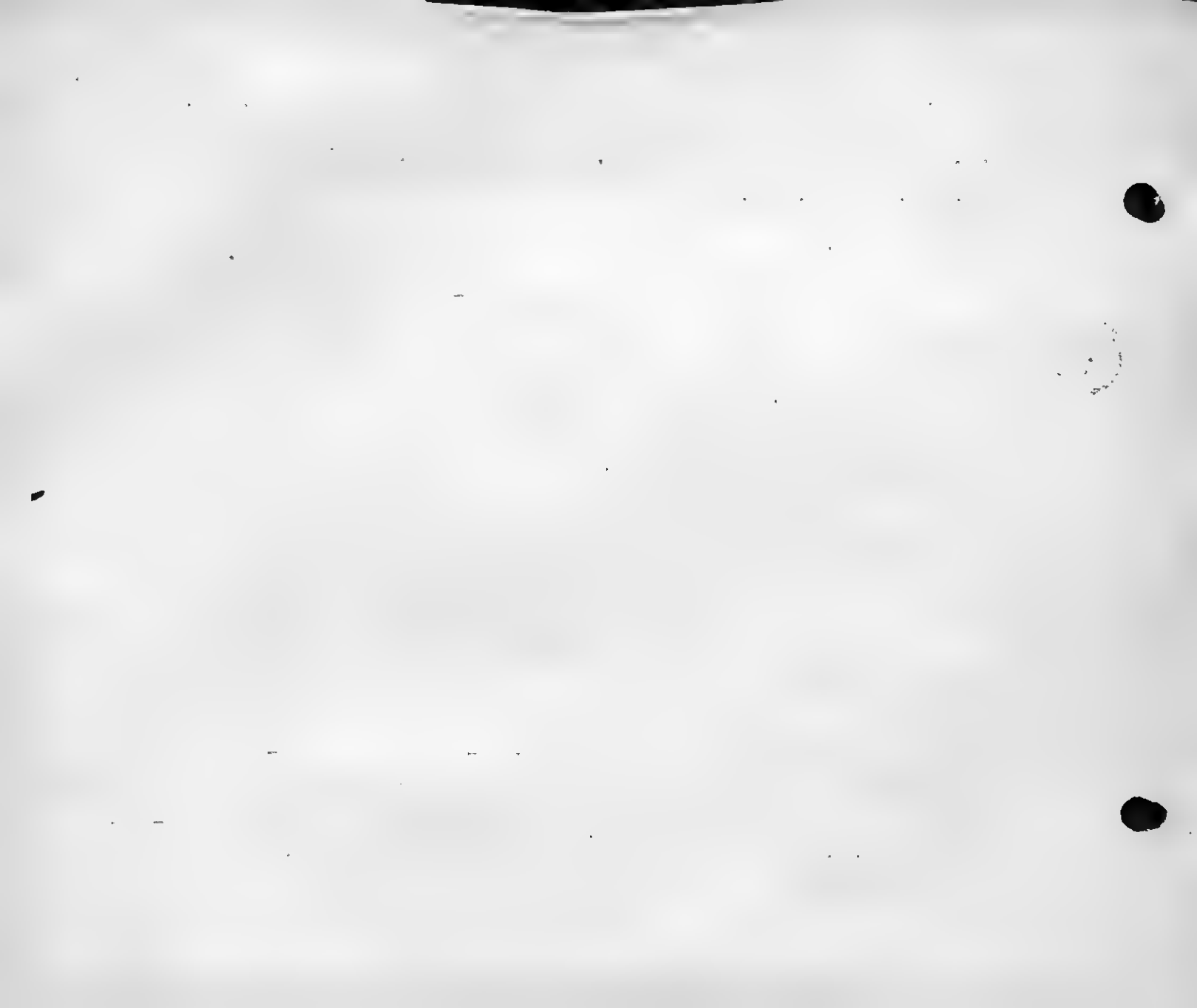
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove covering papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

Items 9, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 1, Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 5, Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Donie Middle Belle Last Layne		4. DATE OF DEATH Month Feb. Day 13 Year 1969	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-11-1876
9. AGE (In years last birthday) 19392 yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Appomatox Va		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Robert W. Martin		14. MOTHER'S MAIDEN NAME Mary Willie Nash	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular renal disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-10-67 , 19____, to 2-13-69 , 19____, that (I) (we) last saw the deceased alive on 2-11-1969 , and that death occurred 12:10 PM from the causes and on the date stated above.			
22a. SIGNATURE Philip A. Insley M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 2-15-69	
22c. PHYSICIAN'S NAME (Type) Philip A. Insley		22d. ADDRESS 116 East Main St. Salisbury, Md	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 16, 1969	
23c. NAME OF CEMETERY OR CREMATORY Belle Haven Va		23d. LOCATION (City, town, or county) (State) Belle Haven Va	
24. FUNERAL DIRECTOR'S SIGNATURE Myrtle Jones Mapp, Belle Haven		ADDRESS	
25a. REC'D BY REGISTRAR Feb 19 1969		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03115

04675

1. DECEASED-NAME (Type or print) First Middle Last <u>Fannie</u> <u>Mason</u> <u>Lewis</u>			2a. DATE OF DEATH Month Day Year <u>2-27-69</u>			2b. HOUR <u>1:30 PM</u>	
3. SEX <u>Female</u>		4. RACE <u>Negro</u>		5. DATE OF BIRTH <u>11-07-00</u>		6. AGE (In years last birthday) <u>68</u> YRS	
7a. BIRTHPLACE (State or foreign country) <u>Louisiana</u>		7b. CITIZEN OF WHAT COUNTRY? <u>US</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Wicomico</u> Md	
10. CITY OR TOWN OF DEATH <u>Salisbury</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Wicomico Nursing Home</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Domestic</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Wicomico</u>		13c. CITY OR TOWN <u>Salisbury</u>		13d. INS DE CITY, M TS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <u>Route 2</u>		14. FATHER'S NAME First Middle Last <u>Clarence</u> <u>Mason</u>		15. MOTHER'S MAIDEN NAME First Middle Last <u>Ann</u> <u>Lewis</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <u>084-01511</u>		17. INFORMANT <u>Theodore Lewis</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> <u>1971</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>2-17</u> , 19 <u>69</u> , to <u>2-27</u> , 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>2-26</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE <u>Thom J. Wrenn</u>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>3-5-69</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calverton Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Calverton VA</u>	
24. FUNERAL DIRECTOR <u>Boater 777 collect</u>				25a. REC'D BY REGISTRAR DATE <u>MAR 12 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)		First <i>Jessie</i>		Middle <i>LEWIS</i>		Last <i>LEWIS</i>		2a DATE OF DEATH Month Day Year <i>FEBRUARY 14 1969</i>		2b HOUR 5:55 M
3 SEX <i>MALE</i>	4 RACE <i>NEGRO</i>		5 DATE OF BIRTH <i>unknown</i>		6 AGE (in years at birthday) <i>unknown</i>		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>unknown</i>		7b CITIZEN OF WHAT COUNTRY? <i>USA?</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH <i>Wicomico</i>		Md		
10 CITY OR TOWN OF DEATH <i>Salisbury</i>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Peninsula General Hospital</i>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MARY.</i>		13b COUNTY <i>WICOMICO</i>		13c CITY OR TOWN <i>BALTIMORE</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>ACADEMY LANE FLOWER STREET</i>		
14. FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lobar pneumonia, bilateral</i>										<i>1 wk</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>alcoholism, chronic, exposure</i>										<i>chronic</i>
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
<i>ASCVD - Congestive Failure</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No		City or Town		County State		
22a I certify that (I) (this hospital) attended the deceased from <i>2/11</i> , 1969, to <i>2/14</i> , 1969, that (I) (we) last saw the deceased alive on <i>2/14</i> , 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <i>Alberta Mattax Polin</i>		DEGREE <i>MD</i>		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <i>2/16/69</i>				
22d PHYSICIAN'S NAME (Type) <i>ALBERTA MATTAX POLIN</i>		22a ADDRESS <i>CAMEL AVE. SALISBURY, MD.</i>								
23a B. BURIAL (CREMATION REMOVED) (Specify)		23b DATE <i>2-18-69</i>		23c NAME OF CEMETERY OR CREMATORY <i>U. Md. Med. School</i>		23d LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>				
24 FUNERAL DIRECTOR <i>Booker M. West</i>		ADDRESS <i>130 2nd St. Salisbury, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 19 1969</i>		25b REGISTRAR'S SIGNATURE <i>James J. ...</i>				

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print)		First	Middle	Last	2c. DATE OF DEATH Month Day Year		2b. HOUR M	
Annie Jane				LITTLETON	FEBRUARY 28 1969		10:00	
3 SEX	4 RACE	5 DATE OF BIRTH			6 AGE (in years last birthday)	7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN
Female	White	July 17, 1894			74 YRS			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland	USA			Wicomico Md				
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind at work done during most of working life, except retired)		12b KIND OF BUSINESS OR INDUSTRY			
Salisbury	Peninsula General Hospital		Housewife		Own home			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER				
Maryland	Wicomico	Pittsville						
14 FATHER'S NAME First Middle Last		15 MOTHER'S MAIDEN NAME First Middle Last						
Levin Thomas Jones		Lou Parker						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b SOCIAL SECURITY NO (If yes give year or dates of service)		17 INFORMANT Address				
		222-14-3554		Sallie Hall Salisbury				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 470 - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Chronic poisoning</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Serumility</u> 5 yrs 10 yrs								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>2-27, 1969</u> to <u>2-28, 1969</u> , that (I) (we) lost saw the deceased alive on <u>2-28, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b SIGNATURE <u>W. B. Smith</u>		22c. PHYSICIAN'S NAME (Type)		22e ADDRESS SALISBURY Md.		22d DATE SIGNED 2-28-69		
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/3/69		23c NAME OF CEMETERY OR CREMATORY Farlowe		23d LOCATION (City or Town) (County) (State) Pittsville Wicomico Md.		
24 FUNERAL DIRECTOR <u>Peter Whaley Salisbury, Del.</u>		25a. REC'D BY REGISTRAR DATE MAR 6 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

031118

031113

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <i>John W. Long</i>			2a. DATE OF DEATH Month <i>2</i> Day <i>24</i> Year <i>69</i>			2b. HOUR <i>11 1/2</i> AM					
3 SEX <i>male</i>		4 RACE <i>Cal</i>		5 DATE OF BIRTH <i>3-3-1900</i>		6 AGE (In years last birthday) <i>68</i> YRS.		7 F UNDER 1 YEAR MONTHS DAYS		8 F UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Wisconsin</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Wisconsin</i>					
10. CITY OR TOWN OF DEATH <i>Salesbury</i>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Booth St 521</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>laborer</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>grocery</i>		
13a. USUAL RESIDENCE (where deceased lived, if institution: Residence before admission) <i>md</i>			13b. COUNTY <i>Wic. Sales.</i>			13c. CITY OR TOWN <i>Sales.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>521 Booth St</i>	
14 FATHER'S NAME First <i>John</i> Middle <i>Long</i> Last <i>Long</i>			15 MOTHER'S MAIDEN NAME First <i>Susan</i> Middle <i>Conway</i> Last <i>Long</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <i>219-34427</i>			17 INFORMANT <i>Iris Long</i>			Address		
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY <i>4109</i> IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Artery Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i> <i>2 1/2 years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Arterio Sclerosis</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 19, 1969</i> , to <i>2-24, 1969</i> , that (I) (we) last saw the deceased alive on <i>Jan 19, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>G. Herbert Semblly MD</i>			22c. DATE SIGNED <i>2/27/69</i>			22d. PHYSICIAN'S NAME (Type) <i>G. Herbert Semblly MD</i>					
23a. BURIAL CREMATION (Remove appropriate)			23b. DATE <i>3-1-69</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Green Acres Cem</i>			23d. LOCATION (City or Town) (County) (State) <i>Salesbury Md.</i>		
24 FUNERAL DIRECTOR <i>Doc Beecher</i>			ADDRESS			25a. REC'D BY REGISTRAR DATE <i>MAR 3 1969</i>			25b. REGISTRAR'S SIGNATURE <i>John L. Yager</i>		

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
WILLIAM JAMES MITCHELL						Month Day Year		HOUR	
3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
M	W	10-23-1923	45 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year	HOUR
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		2d. HOUR	
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Wicomico		10 M	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury, Maryland			Peninsula General Hospital			Laborer, Boat Const. Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. STREET AND NUMBER	
Maryland			Wicomico			Salisbury		Green Street	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Franklin James Mitchell			Alma Virginia Morris						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			
Yes			218-05-8662			Mrs. Jeanette Mitchell (wife)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									days
IMMEDIATE CAUSE (a) Broncho pneumonia									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									days
(b) 3rd degree burns									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
			12:10 PM 2-11-69			Burned in house fire.			
21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or RFD No City or Town County State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			home of friend			Elmwood St., Salisbury, Wicomico, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			Dr. Earl L. Royer			Feb. 17 /69			
			407 Camden Avenue, Salisbury, Md.			ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
Burial			2-17-69			Wicomico Memorial Park			Salisbury, Wicomico, Maryland
24. FUNERAL DIRECTOR			HOLLOWAY and Company			SALISBURY, Maryland			25a. REC'D BY REGISTRAR
									25b. REGISTRAR'S SIGNATURE
						FEB 20 1969			nd



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03120 CERTIFICATE OF DEATH 03115										
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR M		
EDWIN			DANIEL PARSONS			February 25		1969		
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Male		White		July 29, 1908		60 YRS.				
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Maryland		USA				WICOMICO				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Parsonsburg			in village			Painter		painting		
13a. USUAL RESIDENCE (Where deceased lived, admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Wicomico		Parsonsburg		YES <input type="checkbox"/> NO <input type="checkbox"/>		in village	
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Laird W. Parsons			Carrie Bailey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT (Sister) Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
Yes			War II		Mrs. Laura P. Elzey, Salisbury, Maryland 151 W. Fairfield Dr.		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of lung with</u> DUE TO, OR AS A CONSEQUENCE OF <u>general metastases -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>3 months</u> DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Above</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
1/29		as above (biopsy)								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>9/12</u> , 19 <u>67</u> , to <u>death</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>7/24</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Ernest Larmore</u>				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED February 25/1969		
22d. PHYSICIAN'S NAME (Type) Dr. Ernest M. Larmore				22e. ADDRESS Grove Street, DeJmar, Delaware						
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCALITY (City or Town) (County) (State)				
Burial		Feb. 27, 1969		Parsonsburg Cemetery		Parsonsburg, Wicomico, Maryland				
24 FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
HOLLOWAY & COMPANY, SALISBURY, MARYLAND				FEB 28 1969		<u>Charles Young</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

03121

CERTIFICATE OF DEATH

03116

1. DECEASED-NAME (Type or print) LOUISE EMMA		(Middle) PEIFFER		(Last) BAILEY		2a. DATE OF DEATH Month February Day 19 Year 1969		2b. HOUR 10 AM	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH August 25, 1897		6. AGE (In years last birthday) 71 YRS		7. UNDER YEAR MONTHS 71 DAYS 10 HOURS 10 MIN.	
7a. BIRTH-PLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Floor Lady		12b. KIND OF BUSINESS OR INDUSTRY Laundry			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		3a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 105 Benjamin Avenue	
14. FATHER'S NAME First James Middle B. Last Elliott		15. MOTHER'S MAIDEN NAME First Emma Middle Ellis Last Ellis		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					
16b. SOCIAL SECURITY NO. 214-10-9080		17. INFORMANT (Son) Mr. Milton Bailey, Salisbury, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC METASTASIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a): 174 174 1. CARCINOMA OF BREAST (L) DUE TO, OR AS A CONSEQUENCE OF lost. (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MOS 9 MOS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION 10/4/68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ABOVE (B)		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10/11 , 19 68 , to 2/19 , 19 69 , that (I) (we) last saw the deceased alive on 2/19 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE John M. Bloxom III M.D.		22c. DATE SIGNED 2/19/1969		22d. PHYSICIAN'S NAME (Type) JOHN M. BLOXOM III					
22e. ADDRESS MEDICAL CENTER, SALISBURY									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 21, 1969		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR FEB 21 1969		25b. REGISTRAR'S SIGNATURE [Signature]					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03122

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 03117
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <i>TEGLY Sue FENTER</i>			2a. DATE OF DEATH Month <i>February</i> Day <i>7</i> Year <i>1969</i>			2b. HOUR <i>M</i>							
3 SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5 DATE OF BIRTH <i>2-27-1945</i>		6 AGE (in years last birthday) <i>23</i> YRS.		7 UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		7 UNDER 24 HRS HOURS <i></i> MIN <i></i>			
7a BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Wicomico</i>							
10. CITY OR TOWN OF DEATH <i>Salisbury</i>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Peninsula General Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>				
13a. U.S.A. RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>VIRGINIA</i>			13b. COUNTY <i>Accomack</i>			13c. CITY OR TOWN <i>FERGUS BRIDGE</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>Sanford</i>	
14. FATHER'S NAME First <i>Harvey</i> Middle <i></i> Last <i>White</i>			15. MOTHER'S MAIDEN NAME First <i>Lillian</i> Middle <i>Shaw</i> Last <i></i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>			16b. SOCIAL SECURITY NO <i>231-58-3861</i>			17 INFORMANT <i>William Joseph Porter</i> Address <i></i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <i>Malignant</i>													
DUE TO, OR AS A CONSEQUENCE OF <i>Ovarian Cancer with Metastasis</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)			21b. TIME OF INJURY HOUR A.M. <i>19</i> Month <i></i> Day <i></i> Year <i></i> P.M. <i></i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. <i></i> City or Town <i></i> County <i></i> State <i></i>							
22a. I certify that (I) (this hospital) attended the deceased from <i>2/3/69</i> , to <i>2/7/69</i> , that (I) (we) last saw the deceased alive on <i>2/3/69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE <i>William S. Womack</i>			DEGREE <i></i> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>			22c. DATE SIGNED <i>2/11/69</i>							
22d. PHYSICIAN'S NAME (Type) <i>WILLIAM S. WOMACK</i>			22e. ADDRESS <i>AMER ALC SALBURY, MD</i>										
23a. BURIAL, CREMATION, REMOVAL, (Specify) <i>BURIAL</i>			23b. DATE <i>2-3-69</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Downing's</i>			23d. LOCATION (City or Town) (County) (State) <i>Oak Hill - Accomack - Va</i>				
24. FUNERAL DIRECTOR <i>James N. Fox - Temperanceville</i>			ADDRESS <i></i>			25a. RECD BY REGISTRAR <i>FEB 4 1969</i> DATE			25b. REGISTRAR'S SIGNATURE <i>James N. Fox</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The now requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03125

03118

1 DECEASED-NAME (Type or print) Ernest Leamore Powell			2a. DATE OF DEATH Month 2 Day 16 Year 69			2b. HOUR 11:20 AM	
3 SEX Male		4 RACE White		5. DATE OF BIRTH 5/25/1912		6 AGE (In years last birthday) 56 YRS.	
7a. BIRTHPLACE (State or foreign country) W. Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Wicomico Md.	
10. CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Deer's Head State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Teacher		12b. KIND OF BUSINESS OR INDUSTRY Industrial Arts	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 508 Woodcrest Ave.		14 FATHER'S NAME First William Edgar Middle Powell Last Powell		15. MOTHER'S MAIDEN NAME First Frances Middle R. Last Collins			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 232-10-0562		17 INFORMANT Mrs. Angie O. Powell Address 508 Woodcrest Avenue, Salisbury, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma of Rt. Lung with Metas- DUE TO, OR AS A CONSEQUENCE OF tases to Brain - Pelvis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. If YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. _____ Month _____ Day _____ Year 1969 P.M. _____		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No _____ City or Town _____ County _____ State _____			
22a. I certify that (I) (this hospital) attended the deceased from Feb. 14, 1969 , to 2/16 , 19 69 , that (I) (we) lost saw the deceased alive on Feb. 16, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles H. Winnacott, M.D.				22c. DATE SIGNED 2/16/69		22d. PHYSICIAN'S NAME (Type) Charles H. Winnacott, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-19-1969		23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens		23d. LOCATION (City or Town) (County) (State) SALISBURY, MARYLAND	
24. FUNERAL DIRECTOR HOLLOWAY AND COMPANY				25a. RECD BY REGISTRAR FEB 21 1969		25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03124

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03119

1 DECEASED NAME (Type or print) First Middle Last HERBERT EDGAR POWELL			2a. DATE OF DEATH Month Day Year February 26, 1969			2b. HOUR 3:45 A M				
3 SEX Male		4 RACE White		5. DATE OF BIRTH Feb. 6 1897		6. AGE (In years last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH WICOMICO Md				
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Deer's Head State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Truck Farm				
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admiss an) STATE Maryland		13b. COUNTY Worcester		13c. CITY OR TOWN Snow Hill		13d. INSIDE CITY, M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Rt. #2		
14. FATHER'S NAME First Middle Last Elijah T. Powell			15. MOTHER'S MAIDEN NAME First Middle Last Martha Figgs							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) NO		16b. SOCIAL SECURITY NO 220 32 9909		17. INFORMANT Calvin L. Powell, 1022 Galt Ave, Boothwyn, Pa.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral metastatic carcinoma of the lung DUE TO OR AS A CONSEQUENCE OF (primary site unknown) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from February 18, 1969 , to February 26, 1969 , that (I) (we) last saw the deceased alive on February 26, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, XX (we) (did) (not) view the body after death.										
22b. SIGNATURE C. H. Winnacott					DEGREE MD		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/26/69	
22d. PHYSICIAN'S NAME (Type) C. H. Winnacott, M. D.					22e. ADDRESS Maryland Deer's Head State Hospital, Salisbury,					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 28, 1969		23c. NAME OF CEMETERY OR CREMATORY Bates Memorial Meth.			23d. LOCATION (City or Town) (County) (State) Snow Hill Md.			
24. FUNERAL DIRECTOR Norman F. Morris, Snow Hill, Md.					25a. REC'D BY REGISTRAR MAR 3 1969		25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03125

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03120

1. DECEASED-NAME (Type or print) SAMUEL LEVI QUILLEN			2a. DATE OF DEATH Month February Day 12 Year 1969			2b. HOUR 6:30 M
3. SEX Male	4. RACE white	5. DATE OF BIRTH JAN 29 1891		6. AGE (In years last birthday) 78 YRS.	IF UNDER 1 YEAR MONTHS 12 DAYS 12 HOURS 30 MIN	IF UNDER 24 HRS HOURS 30 MIN
7a. BIRTHPLACE (State or foreign country) BERLIN MD	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.		
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) COAST GUARD		12b. KIND OF BUSINESS OR INDUSTRY RETIRED
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MARYLAND		13b. COUNTY WORCESTER	13c. CITY OR TOWN OCEAN CITY	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 900 N. PHILA. AVE	
14. FATHER'S NAME First SAMUEL T. Middle QUILLEN Last JENNIE			15. MOTHER'S MAIDEN NAME First JENNIE Middle HOLLAND Last HOLLAND			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown YES (If yes give war or dates of service) WORLD WAR II		16b. SOCIAL SECURITY NO. 100-11-12		17. INFORMANT Address Mrs S.L. Quillen Ocean City MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia infection 450X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from 2-7 , 19 66 to 2-12 , 19 69 , that (I) (we) last saw the deceased alive on 2-12 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Wilbur R. Ellis, Jr.				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 2-18-69
22d. PHYSICIAN'S NAME (Type) Wilbur R. Ellis, Jr.				22e. ADDRESS MEDICAL CENTER Salisbury MD		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2/15/69		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION (City or Town) (County) (State) BERLIN WICOMICO MD
24. FUNERAL DIRECTOR Anna A. Burbridge Berlin Md				25. RECEIVED BY REGISTRAR FEB 19 1969		25b. REGISTRAR'S SIGNATURE [Signature]

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03126

03121

1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>		c. LENGTH OF STAY IN 1b <u>All Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>R.T.D</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>HALLIE O Reed</u>		4 DATE OF DEATH Month Day Year <u>2 24 1969</u>	
5 SEX <u>F.</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-1898</u>
9 AGE (In years last birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR Months Days Hours M n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>LABORER</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>ROXBURY, N.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>ANNA?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-18-2905</u>	
17 INFORMANT <u>GRACE JAMES</u> Address <u>Fruitland, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Hypertolic pneumonia</u> DUE TO <u>Cardiac Failure</u> (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>13 days</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Apr. 1967</u> , to <u>Feb 24, 1969</u> , that (I) (we) last saw the deceased alive on <u>Feb 23, 1969</u> , and that death occurred at <u>6:10 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>B. Frank Giganti</u>		22b. DATE SIGNED <u>Feb 25, 1969</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. FRANK GIGANTI</u>		22d. ADDRESS <u>Princes Anne Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>3-2-69</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CAPE CHARLES</u>	23d. LOCATION (City or Town) (County) (State) <u>CAPE CHARLES Northampton, Va.</u>
24. FUNERAL DIRECTOR <u>Folley Memorial Chapel</u>		25a. REC'D BY REGISTRAR <u>5 1969</u>	
ADDRESS <u>2144 Rt. 2 & 2</u>		25b. REGISTRAR'S SIGNATURE <u>K. L. ...</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MIDDLE										LAST										2a. DATE OF DEATH										2b. HOUR																													
1. DECEASED-NAME (Type or print) HAZEL										ELIZABETH										Taylor										February 3 1969										4:30 A M																			
3. SEX Female										4. RACE White										5. DATE OF BIRTH 10-30-1903										6. AGE (In years last birthday) 65										7. IF UNDER 1 YEAR MONTHS DAYS										8. IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) Maryland										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH Wicomico										Md.																			
10. CITY OR TOWN OF DEATH Salisbury										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife										12b. KIND OF BUSINESS OR INDUSTRY --																													
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland										13b. COUNTY Worcester										13c. CITY OR TOWN Pocomoke										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER R.F.D. 2																			
14. FATHER'S NAME First Middle Last Noah W. McGee										15. MOTHER'S M.A.DEN NAME First Middle Last Martha Emily Butler										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No										16b. SOCIAL SECURITY NO. none										17. INFORMANT Address W. T. Taylor, Pocomoke City, Maryland																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										PART 1. DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a) Multiple Pulmonary Infarcts										DUE TO, OR AS A CONSEQUENCE OF																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										(b) Suspected phlebotic in lower extremities										DUE TO, OR AS A CONSEQUENCE OF										(c)																													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										Barbiturate Habitualism										19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)										21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING ETC)										21f. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that (I) (this hospital) attended the deceased from 1-16-69 , to 2-3-69 , that (I) (we) last saw the deceased alive on 2-3-1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										22b. SIGNATURE James L. Clifford										22c. DATE SIGNED 2-4-69										22d. PHYSICIAN'S NAME (Type) James L. Clifford										22e. ADDRESS Medical Center Salisbury Md																			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial										23b. DATE 2-6-1969										23c. NAME OF CEMETERY Salem Methodist										23d. LOCATION (City or Town) (County) (State) Pocomoke City, Wor., Md.																													
24. FUNERAL DIRECTOR Robert N. Walsan										ADDRESS Pocomoke City, Md.										25a. RECEIVED BY REGISTRAR FEB 7 1969										25b. REGISTRAR'S SIGNATURE Robert N. Walsan																													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03128

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

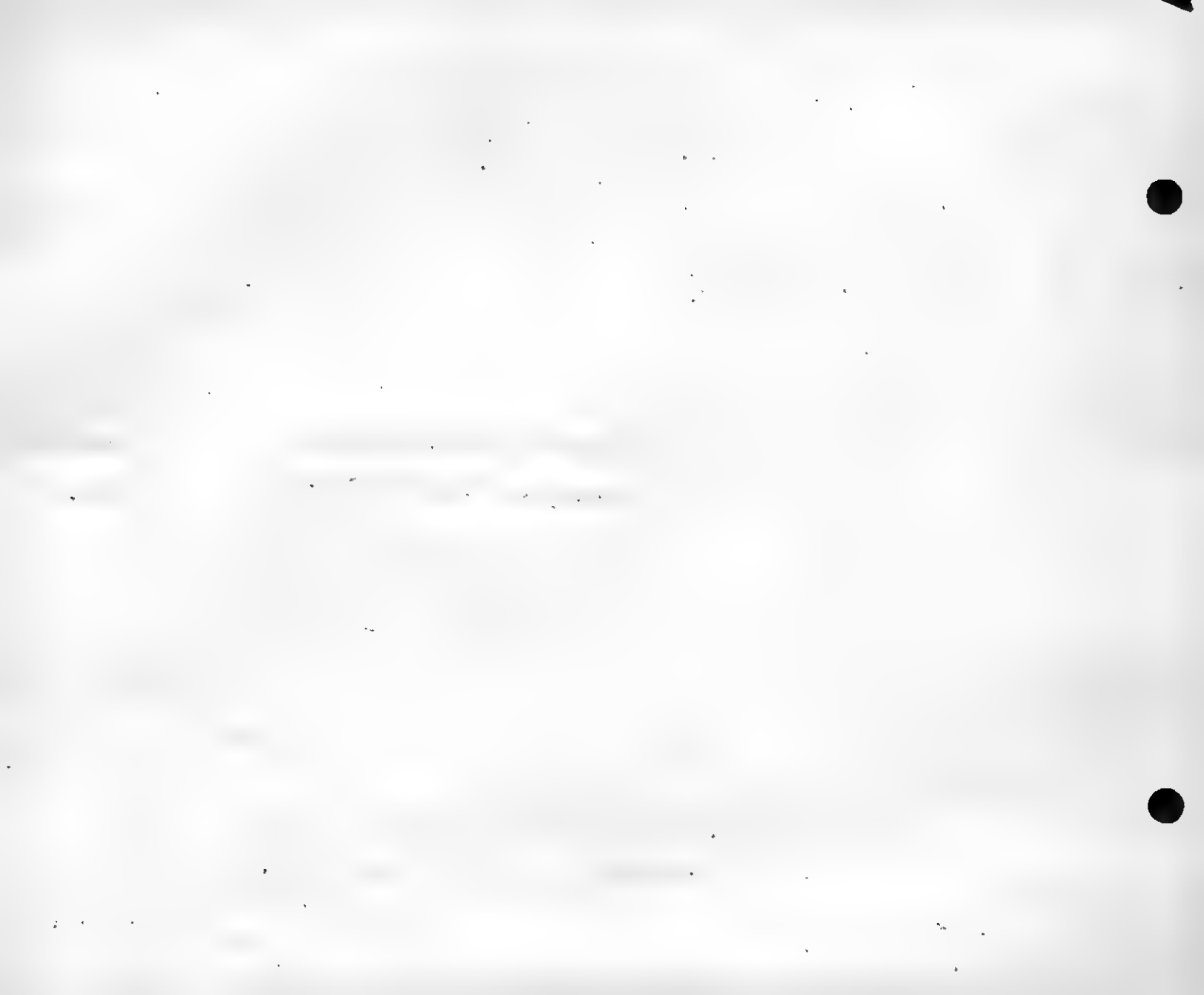
03123

1. DECEASED NAME (Type or print) TESSIE			First Middle Last			2a. DATE OF DEATH Month Day Year February 5, 1969			2b. HOUR 6:25 PM		
3 SEX Female			4 RACE Colored			5 DATE OF BIRTH Aug 10 - 1890			6 AGE (In years last birthday) 78 YRS		
7a BIRTHPLACE (State or foreign country) N.C.			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH WICOMICO Md		
10. CITY OR TOWN OF DEATH Salisbury			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Deer's Head State Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Domestic			12b. KIND OF BUSINESS OR INDUSTRY none		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b COUNTY Wicomico			13c CITY OR TOWN Salisbury			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last Unknown			15. MOTHER'S MAIDEN NAME First Middle Last Unknown			13e STREET AND NUMBER 225 Catherine Street					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) yes			16b SOCIAL SECURITY NO 219-65-3276			17 INFORMANT Mildred Johnson			Address		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Epidermoid carcinoma of cervix, stage 3, with metastasis 100X DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pulmonary tuberculosis, inactive											
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State					
22a I certify that XX (this hospital) attended the deceased from January 28, 1969 , to February 5, 1969 , that (4) (we) last saw the deceased alive on February 5, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE L. V. Maldve, M.D.						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			22c DATE SIGNED 2/6/69		
22d PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.						22e ADDRESS Deer's Head State Hospital, Salisbury, Maryland					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE 2-8-69			23c NAME OF CEMETERY OR CREMATORY Green Acres Cem			23d LOCATION (City or Town) (County) (State) Salisbury Md		
24. FUNERAL DIRECTOR Booker M. West						25a. REC'D BY REGISTRAR FEB 11 1969			25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month / Day / Year		2b. HOUR M			
RENA			JANE	TEMPLETON	2 / 24 / 69						
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR MONTHS / DAYS			
Female		White		Sept. 17, 1888		80 YRS.					
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Maryland			U.S.				Memor				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Delmar			Home			Teacher		Home			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Md			Memor		Delmar		YES <input type="checkbox"/> NO <input type="checkbox"/>		205		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S M.A.DEN NAME			First	Middle	Last
John					Dorsey	Alberta					Ennis
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17 INFORMANT			Address
						712-081		Mrs Anna Truitt			Delmar Md
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u>										10 minutes	
4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary atherosclerotic disease</u>										1 year	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No			City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>4/6</u> , 19 <u>69</u> , to <u>death</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>2/22</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Ernest Larmore</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>2/25/69</u>			
22d PHYSICIAN'S NAME (Type) <u>E. M. LARMORE</u>						22e. ADDRESS <u>DELMAR DEL.</u>					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Burial			2/24/69		St Stephens			Delmar Sussex Del			
24 FUNERAL DIRECTOR <u>William J. Morrell</u>						ADDRESS <u>Delmar Del.</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
								FEB 28 1969		<u>Charles Judge</u>	



CERTIFICATE OF DEATH

03130

03125

1. DECEASED NAME (Type or print) EDNA MARTHA THOMAS			2a. DATE OF DEATH Month February Day 27 Year 1969			2b. HOUR 3:00A M	
3. SEX Female		4. RACE Colored		5. DATE OF BIRTH Nov. 11, 1900		6. AGE (In years last birthday) 68 YRS.	
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WICOMICO Md	
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Deer's Head State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Farm	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Worcester		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER Rt. #3		14. FATHER'S NAME First Moses Middle Costen Last Rowley		15. MOTHER'S MAIDEN NAME First Abbie Middle Rowley Last Rowley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO 218-16-7374D		17. INFORMANT Annie E. Bailey		Address Stockton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of endometrium with metastasis 18x0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Cerebral vascular accident; diabetes mellitus.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from February 24, 1969 , to February 27, 1969 , that (2) (we) lost saw the deceased alive on February 27, 1969 , and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (4) (we) (did) (did not) view the body after death.							
22b. SIGNATURE L. V. Maldve, M. D.		22c. DATE SIGNED 2/27/69		22d. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22e. ADDRESS Deer's Head Hospital; Salisbury, Maryland	
23a. BURIAL CREMATION REMOVAL (Specify) Burial		23b. DATE 3-1-69		23c. NAME OF CEMETERY OR CREMATORY Georgetown Cem.		23d. LOCATION (City or Town) (County) (State) Pocomoke Wor. Md.	
24. FUNERAL DIRECTOR Samuel Lewis		25a. REC'D BY REGISTRAR MAP		25b. REGISTRAR'S SIGNATURE William B. Jordan		25c. DATE 3 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3 (Page 5 may be retained for your files).

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div>03131</div> <div>03126</div>									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)					First Middle Last		2a DATE KNOWN OF DEATH		2b HOUR
WILLIAM A. TOWNSEND							<input checked="" type="checkbox"/> Month Day Year <input type="checkbox"/> 2-3-69 19 7:35 P.M.		<input type="checkbox"/> 7:35 P.M.
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 MONTHS	8 DAYS	9 HOURS	10 MIN	2c DATE PRONOUNCED DEAD	
Male	White	9-6-04	64 YRS					Month 2 Day 3 Year 19 7:35 P.M.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Md.		U.S.A.				Wicomico Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Salisbury			Peninsula General			Truck Farmer			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER
Md.			Worcester		Newark		YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
George Townsend			Mary Turner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS				
No			217-36-0543		Mrs. Ethel Townsend (wife) as per #13				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4107</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									sudden
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. P.M. 19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b DATE SIGNED	
<u>Carl L. Royer, M.D.</u>		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		Feb. 4, 1969	
EXAMINER'S NAME (Type)		ADDRESS (Street, city, town, or county)							
409 Camden Ave., Salisbury, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Feb. 4, 1969		Trinity Garden of Memories		Newark Maryland			
24. FUNERAL DIRECTOR				25a. REC'D BY REG. STAMP		25b. REGISTRAR'S SIGNATURE			
Dennis Funeral Home, Snow Hill, Md.				FEB 1 1969					

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03132

03127

1. DECEASED NAME (Type or print) Nettie Mae TURNER			2a. DATE OF DEATH Month FEBRUARY Day 6 Year 1969 10 15 AM	
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH 1-15-95		6. AGE (in years lost birthday) 74 YRS.
7a. BIRTHPLACE (State or foreign country) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Wicomico Md	
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE Virginia	13b. COUNTY Accomack	13c. CITY OR TOWN Onley	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER
14. FATHER'S NAME First Middle Last Edward T. Turner		15. MOTHER'S MAIDEN NAME First Middle Last Mary Lingo		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT Margaret Turner Va. Beach, Va.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Arterio-sclerotic Heart Disease 4123 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from 2-5 , 19 69 , to 2-6 , 19 69 , that (I) (we) last saw the deceased alive on 2-6 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Wilber R. Ellis, Jr.		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 2-6-69
22d. PHYSICIAN'S NAME (Type) WILBER R. ELLIS, Jr.		22e. ADDRESS MEDICAL CENTER SALISBURY, MD.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2-8-69	23c. NAME OF CEMETERY OR CREMATORY Belle Haven		23d. LOCATION (City or Town) (County) (State) Belle Haven Accomack Va.
24. FUNERAL DIRECTOR Ellis, Williams & O'NEAL, VA.		25a. REC'D BY REGISTRAR FEB 10 1969		25b. REGISTRAR'S SIGNATURE [Signature]

CERTIFICATE OF DEATH

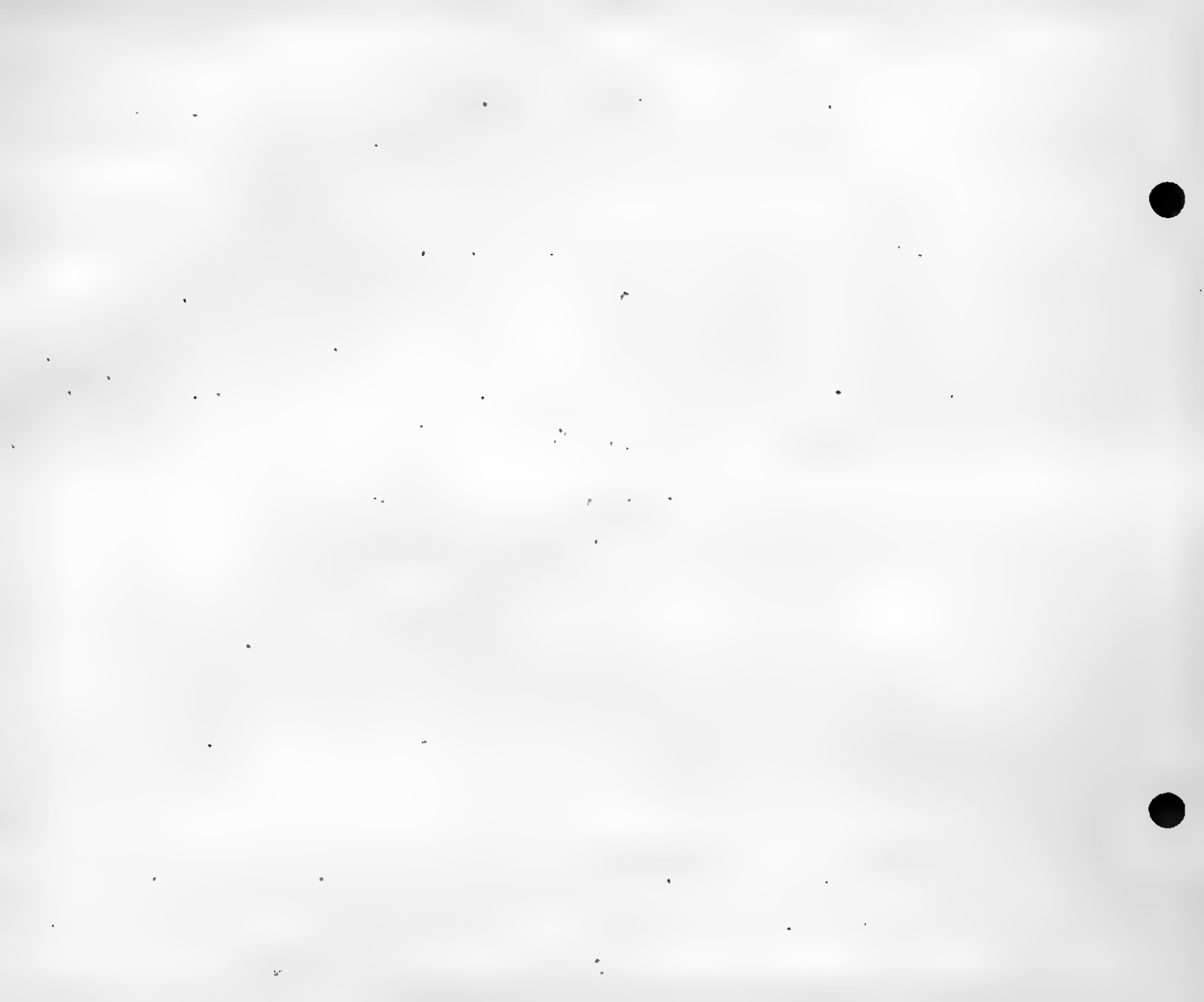
03133

03128

1 DECEASED NAME (Type or print) KATIE			First Middle Last GOSTILL VALENTINE			2a. DATE OF DEATH Month 2 Day 16 Year 1969			2b. HOUR 10:30 ^P					
3 SEX F			4 RACE W			5. DATE OF BIRTH April 7 1888			6 AGE (In years last birthday) 80 YRS.			7 UNOER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Wicomico Md					
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Palmsala General Hosp			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife			12b. KIND OF BUSINESS OR INDUSTRY own no ie					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Wicomico			13c. CITY OR TOWN Salisbury			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 213 Davis St.		
14. FATHER'S NAME First Middle Last August Pfeiffer			15. MOTHER'S MAIDEN NAME First Middle Last unknown											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 220-20-9076			17. INFORMANT Mrs. Agnes Davis			Address 213 Davis St. Salisbury Md see sec. 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive failure DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min 1 mo			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from 1-14, 1969 , to 2-16 1969 , that (I) (we) last saw the deceased alive on 2-15 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Frank J. Weaver, Jr.						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 2-17-69					
22d. PHYSICIAN'S NAME (Type) Frank Weaver, Jr.						22e. ADDRESS Carroll Ave. Salisbury, Md.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/20/1969			23c. NAME OF CEMETERY OR CREMATORY London Park Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore Maryland					
24. FUNERAL DIRECTOR Hill Funeral Home						ADDRESS Salisbury			25a. RECD BY REGISTRAR DATE FEB 19 1969			25b. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03134

**MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

03123

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH ESTIMATED			Month	Day	Year	2b HOUR	
ETHEL MINNIE (HAYMAN) WALKER						2/10 1969						8:20 P.M.	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD			Month	Day	Year
Female	White	May 16, 1894	74 YRS.					February 10 1969					8:20 P.M.
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WICOMICO Md							
Maryland		USA											
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY				
Salisbury			Peninsula General Hospital			Housework			----				
13a USUAL RESIDENCE (Where deceased lived, if admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER				
Maryland			Wicomico		Salisbury				730 Roger Street				
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last		
Josephus Wilson						Lina Shockley							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT (Son)			ADDRESS R.D. 1				
No						Mr. Eldridge W. Hayman, Salisbury, Maryland							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			Earl L. Royer, M.D. 409 Camden Ave., Salisbury, Md.			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b DATE SIGNED February 13/1969				
23a B. URIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)					
Burial			Feb. 13, 1969		Parsons Cemetery			Salisbury, Wicomico, Maryland					
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE FEB 17 1969					



**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03135

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03130

1. DECEASED-NAME (Type or Print)		First MARY	Middle L.	Last WATERS	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Month Day Year 2-17-69 19		2b. HOUR 9:15 A.M.	
3. SEX Female	4. RACE AA	5. DATE OF BIRTH 1-10-1888		6. AGE (in years last birthday) 81 YRS	7. UNDER 1 YEAR MONTHS DAYS	8. UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 2 Day 17 Year 69	2d. HOUR 9:15 A.M.
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico		Md
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. COUNTY Somerset		13c. CITY OR TOWN Upper Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
14. FATHER'S NAME First Levin		Middle T.		Last Waters		15. MOTHER'S MAIDEN NAME First Laura		Middle Waters
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Harold Waters		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchial obstruction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Smoke inhalation</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month Day, Year 8 A.M. 2-15-69		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) House fire at own home.				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory office building, etc.) own home		21f. LOCATION Street or R.F.D. No City or Town County State Upper Hill, Somerset, Md.				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspect on <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Earl L. Royer, M.D. 409 Camden Ave., Salisbury, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED Feb. 21, 1969		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2-21-69		23c. NAME OF CEMETERY OR CREMATORY Centennial Cemetery		23d. LOCATION (City or Town) (County) (State) Fairmount, Somerset, Md.		
24. FUNERAL DIRECTOR ADDRESS		Anthony Ward, Crisfield, Md.		25a. REC'D BY REGISTRAR DATE FEB 26 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
03136											
03132											
1 DECEASED NAME (Type or print)			First		Middle		Last		2a DATE OF DEATH Month Day Year		
LOUIS			JOHN		WEINTZ		FEBRUARY 12 1969		2b HOUR 12 PM		
3 SEX		4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
MALE		white		4/21/1885			83 YRS.				
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
New York			USA				Wicomico Md				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury			Peninsula General Hospital			Tech. Engr.			Engineering		
13a USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland			Wicomico		Salisbury				522 Alabama Ave. Apt. E		
14 FATHER'S NAME			First		Middle		Last		15 MOTHER'S MAIDEN NAME		
Henry			Weintz		Katherine		Abel				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO.		17 INFORMANT		18a. ADDRESS				
no			224-01-4257		Mrs. Frank E. Poole		614 Douglas Rd. Salisbury, Md. 21801				
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Failure</u>										2 hrs.	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ruptured abd. aortic aneurysm</u>										24 hrs.	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>William P. Sadler</u>						22c. DATE/SIGNED 2/12/69					
22d. PHYSICIAN'S NAME (Type) WILLIAM P. SADLER						22e. ADDRESS Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			2/17/1969		Evergreen Cemetery			Brooklyn New York			
24 FUNERAL DIRECTOR HILL FUNERAL HOME						ADDRESS Salisbury, Md.		25. FILED BY REGISTRAR FEB 17 1969		25b. REGISTRAR'S SIGNATURE	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1

03137		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				03132	
Item 7 Film 410 3/4/69 kk CERTIFICATE OF DEATH							
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year	
Ada Mae Wheeler						2 Month 16 Day 69 Year	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)	
Female		White		12/1/1897 1894		78 74 YRS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH	
Maryland		USA				Wicomico Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury		Deer's Head State Hospital		Beautician		Beauty Shop	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INS. OR CITY, JAN 15? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Somerset		Crisfield		Chesapeake Avenue	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last				
James E. Wheeler			Sarah M. Greenwell				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17 INFORMANT Address			
No None		195-05-1198		Mrs. Agnes Mason, Norfolk, Va. 1618 Morris Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Encephalopathy - Etiology Unknown</u> 3431 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ???
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Spastic Paraplegia</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan. 15, 1969</u> to <u>Feb. 16, 1969</u> , that (I) (we) last saw the deceased alive on <u>Feb. 16, 1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Charles H. Winnacott</i>				22c. DATE SIGNED 2/16/69		22d. PHYSICIAN'S NAME (Type) Charles H. Winnacott, M.D.	
22e. ADDRESS Deer's Head State Hospital, Salisbury, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		Feb. 18, 1969		Sunnyridge Cemetery		Crisfield, Somerset, Md.	
24 FUNERAL DIRECTOR ADDRESS				25a. RECEIVED REGISTRAR DATE			
Bradshaw & Sons, Crisfield, Md.				FEB 24 1969 REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print) DARNELL			First Middle Last Whittington			2a. DATE OF DEATH Month Day Year February 26 1969		2b HOUR 1:30 M	
3 SEX Male		4 RACE Negro		5 DATE OF BIRTH Jan. 20, 1969		6 AGE (in years last birthday) YRS.		7 UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Md.		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md			
10 CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md.		13b COUNTY Somerset		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
14 FATHER'S NAME First Middle Last Alexander Whittington			15 MOTHER'S MAIDEN NAME First Middle Last Gloria Bishop						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b SOCIAL SECURITY NO —		17 INFORMANT Alexander Whittington - Marion Md Address			
18 CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Gastroenteritis & dehydration DUE TO, OR AS A CONSEQUENCE OF (b) (recurrent) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) RL Lobor, pneumonia; LL lobar pneumonia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hr.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (1) this hospital attended the deceased from 2/22/1969 to 2/26/1969 , that (1) (we) last saw the deceased alive on 2/25/1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death									
22b SIGNATURE Alfred C. Kells M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c DATE SIGNED				
22d PHYSICIAN'S NAME (Type) Alfred C Kells					22e ADDRESS Medical Center Salisbury Md				
23a BURIAL CREMATION REMOVAL (Specify)		23b DATE Feb. 27 '69		23c NAME OF CEMETERY OR CREMATORY Family Cemetery		23d LOCATION (City or Town) (County) (State) Marion Sta, Som. Md.			
24 FUNERAL DIRECTOR Charles H. Ward - Marion Sta, Md. ADDRESS					25a REG. BY REGISTRAR FEB 28 1969 DATE		25b REGISTRAR'S SIGNATURE		

03139

CERTIFICATE OF DEATH

03134

1 DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
BESSIE		ESTHER	WILKINS	February 10		1969		4:40 PM
3 SEX	4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR	
Female	White		August 9, 1908		60 YRS.		IF UNDER 24 HRS	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Maryland		USA				WICOMICO Md.		
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury		Peninsula General Hospital		Seamstress		shirt factory		
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland		Wicomico		Salisbury				303 Carrollton Avenue
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle
Carroll		Ashmead			Sarah Ellen Lambertson			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT (Husband)		Address		
No		218-34-7729		Mr. Thomas G. Wilkins, Salisbury, Maryland		303 Carrollton Ave		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u>								2 days
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from 2-10-1969 to 2-10-1969 that (I) (we) last saw the deceased alive on 2-10-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (aid not) view the body after death.								
22b. SIGNATURE <u>Wilber R. Ellis, Jr.</u>						22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS		
Wilber R. Ellis, Jr.						Medical Center, Salisbury, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		Feb. 13, 1969		St. Stephens Cemetery		Delmar Delaware		
24. FUNERAL DIRECTOR				25a. REC'D BY REG. STRAR		25b. REGISTRAR'S SIGNATURE		
HOLLOWAY & COMPANY, SALISBURY, MARYLAND				FEB 17 1969				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03140

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

03135

1 DECEASED NAME (Type or print) DELORES ELIZABETH WILKINS			2a. DATE OF DEATH Month February Day 27 Year 1969		2b. HOUR 7:50 PM
3 SEX Female	4 RACE White	5. DATE OF BIRTH Sept. 17, 1927		6 AGE (In years last birthday) 41 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	B MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH WICOMICO Md	
10. CITY OR TOWN OF DEATH Salisbury	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Deer's Head State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) No Occupation		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. USUAL RESIDENCE (Where deceased lived if institution. Res denote before admission) STATE Maryland	13b. COUNTY Wicomico	13c. CITY OR TOWN Salisbury	13d. INS OF CITY - MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 313 Prince Street	
14. FATHER'S NAME First Middle Last William Nolker		15. MOTHER'S MAIDEN NAME First Middle Last Evelyn James			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service)		16b. SOCIAL SECURITY NO None	17. INFORMANT Address M. Nazurek 315 Princeton Ave., Salisbury, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma of cervix with extensive metastasis 180x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 months
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes insipidus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 26, 1968 to February 27, 1969 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on February 27, 1969 , and that in our (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (do not) view the body after death					
22b. SIGNATURE L. V. Maldve, M. D.		DEGREE MD		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 22c. DATE SIGNED 2/28/69	
22d. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		22e. ADDRESS Deer's Head State Hospital, Salisbury, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 3-3-1969	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City or Town) (County) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR Hill Funeral Home Salisbury, Maryland		ADDRESS		25a. REC'D BY REGISTRAR MAR 5 1969	25b. REGISTRAR'S SIGNATURE W. L. ...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

03141

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

03136

1. DECEASED-NAME (Type or print) First Middle Last JAMES E. WILSON			2a. DATE OF DEATH Month Day Year FEBRUARY 17 1969			2b. HOUR 11:20 M	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH Aug 2, 1916		6 AGE (in years last birthday) 52 YRS	
7a BIRTHPLACE (State or foreign country) Md		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md	
10 CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Peninsula General Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Teacher	
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Md		13b COUNTY Wicomico		13c CITY OR TOWN Salisbury		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME First Middle Last Samuel Wilson		15 MOTHER'S MAIDEN NAME First Middle Last Ida Graham		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			
16b SOCIAL SECURITY NO 34-55-5715		17 INFORMANT Tyne Wilson		Address Wicomico 16d			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ventricular Standstill</u> DUE TO, OR AS A CONSEQUENCE OF <u>myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF <u>ASCVD</u> (c) <u>years.</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 60 hours
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 2-15, 1969, to 2-17, 1969, that (I) (we) last saw the deceased alive on 2-17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Joseph C. Fitzgerald M.D.				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED 2-19-69	
22d PHYSICIAN'S NAME (Type)				22e ADDRESS			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 2/19/69		23c NAME OF CEMETERY OR CREMATORY Springfield		23d LOCATION (City or Town) (County) (State) Salisbury Wicomico Md	
24. FUNERAL DIRECTOR James E. Wilson				25a REC'D BY REGISTRAR FEB 21 1969		25b REGISTRAR'S SIGNATURE James E. Wilson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR
HARRY					WRIGHT	February 21, 1969			4:00A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Male		White		Jan. 2, 1893		76 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				WICOMICO Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury			Deer's Head State Hospital			Farmer		own farm	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Wicomico		Mardela		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		--
14. FATHER'S NAME First Middle Lost					15. MOTHER'S MAIDEN NAME First Middle Lost				
John A. Wright					Sarah F. Jackson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
			220 09 1377		Albert W. Wright, Ambler Penna.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>									2 days
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary heart failure</u>									1 month
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral vascular accident</u>									1 Month
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (a) (this hospital) attended the deceased from February 12, 1969, to February 21, 1969, that (b) (we) last saw the deceased alive on February 21, 1969, and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (d) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <u>A. C. Mitchell</u>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 2/21/69	
22d. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D.						22e. ADDRESS Maryland Deer's Head State Hospital, Salisbury,			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			2/24/69		Mardela Church Cemetery		Mardela Maryland		
24. FUNERAL DIRECTOR <u>W. L. Deharo</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
						FEB 24 1969		W. L. Deharo	

0312

1000 1000 1000



[The following text is extremely faint and largely illegible due to fading and bleed-through from the reverse side of the page. It appears to be a multi-paragraph document, possibly a letter or a report, with some lines of text visible in the lower half of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
MARGARET			BERTELS	YOUNG	Month Day Year 2 23 1969		10:45		P
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		10-2-1914		54 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New Jersey		U.S.A.				Wicomico Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General Hospital		Sec. Office		Sec.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Wicomico		Salisbury		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		407 E. Vine St.,	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Fred			J.	Bertels, Sr.	Martha			A. Kaestner	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Yes, no, or (unknown) <input checked="" type="checkbox"/> NO		155-14-7691		Nelson		Mr. Ronald Young, Same Sec 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left lung atelectasis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bilateral bronchitis and emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cigarette Smoking (2 PKs/d)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours Years Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cor Pulmonale. Severe pulmonary insufficiency.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>2/3/1969</u> to <u>2/23/1969</u> , that (I) (we) last saw the deceased alive on <u>2/23/1969</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS	
Dr. C. J. Burton		2-25-1969						SALISBURY, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Cremation		2-26-1969		J. William Lee Crematory		Washington, D.C.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Hill Funeral Home		Salisbury, Maryland		FEB 27 1969		Charles Judge			

2076

2010

COPIES